APPENDIX

In the Supreme Court of the United States

October Term, 1977

No. 77-891

FRANK S. BEAL, Secretary of Welfare of the Commonwealth of Pennsylvania, ROBERT P. KANE, Attorney General of the Commonwealth of Pennsylvania, THE COMMONWEALTH OF PENNSYLVANIA, and F. EMMETT FITZPATRICK,

Appellants

vs.

JOHN FRANKLIN, M. D. and OBSTETRICAL SOCIETY OF PHILADELPHIA,

Appellees

On Appeal From the United States District Court for the Eastern District of Pennsylvania

Docketed December 16, 1977

Probable Jurisdiction Noted March 6, 1978

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IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action
No. 74-2440

Planned Parenthood Association of Southeastern Pennsylvania, Inc. et al.

Plaintiffs

vs.

J. Emmett Fitzpatrick, Jr., District Attorney of Philadelphia County

and

Helene Wohlgemuth, Secretary of Welfare of the Commonwealth of Pennsylvania

Defendants

RELEVANT DOCKET ENTRIES

1974	Proceedings	No.
Sept. 20	Complaint filed	1
	* * *	
Sept. 26	Order designating the Hon. Arlin M. Adams, U. S. Circuit Judge and the Hon. Clifford Scott	

TESTIMONY FROM TRANSCRIPT OF RECORD OF PROCEEDINGS BEFORE THE LOWER COURT

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action
No. 74-2440

Planned Parenthood Association of Southeastern Pennsylvania, Inc., et al.

Plaintiffs

vs.

J. Emmett Fitzpatrick, Jr., District Attorney of Philadelphia County

and

Helene Wohlgemuth, Secretary of Welfare of the Commonwealth of Pennsylvania

Defendants

Before: HON. ARLIN M. ADAMS, U.S. Court of Appeals for the Third Circuit

HON. CLIFFORD SCOTT GREEN, and HON. CLARENCE C. NEWCOMER, U. S. District Court for the Eastern District of Pennsylvania

TESTIMONY OF LOUIS GERSTLEY, III, M.D., TAKEN JANUARY 13, 1975

* * * *

(p. 26)

BY MR. MORRIS:

Q. Now, Doctor, is there, or are there one or more critical physical abilities which determine viability, with respect to each individual fetus?

A. Yes. Primarily, the maturity of the lung is the primary thing that determines the ability of a fetus to stand on its own outside the mother's womb.

Beyond that, the viability and adaptability of the liver and hematopoetic system.

Q. Now, Dr. Gerstley, with respect to the maturity of lungs, is this factor expressed in terms of the ability of the lungs to inhale or exhale; or the ability of the tissues to inhale or exhale, or both?

A. Both.

Q. Now, I ask you, Doctor, to assume the presence in your office or your operating theatre, of a pregnant woman, and ask you to explain for the Court what steps you take to determine the stage of the fetus and the likelihood of the viability.

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A. This is done, primarily by two methods: We attempt to establish a historical perspective of the patient, based on what we call her last menstrual period—when she had her last menstrual period.

There are two things involved here: One is, was this a normal menstrual period, or was there an episode of bleeding that was not a true menstrual period.

The other thing is to determine by the size of the uterus the estrapulated size of the fetus.

Q. What is the most-used method to determine the size of the fetus?

A. By the manual method. That is, where we place one or two fingers in the vagina, one hand on the abdomen, and takes the uterus between those two hands, and from that we determine, roughly, the physical size of the fetus.

Q. Are there other methods available in some hospitals?

A. Yes. You could have X-ray or ultrasonography, which is a new method that is coming in, where the size of the uterus can be determined by ultrasound techniques.

Q. Doctor, having made such an examination of a woman and ascertained the size of the fetus, is the size of the fetus then related to any particular time period?

A. Generally, yes; but within limits of error of both of these techniques.

Q. What is that time period?

A. Weeks' gestation.

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Q. Now, is it possible, Doctor, to determine with respect to the patient that I have asked you to assume, having made all the diagnostic tests that I have asked you to prescribe, whether or not the fetus in that mother is viable?

A. Only roughly.

Q. When you say "roughly" how do you say "roughly"?

A. Because there are too many variable factors that occur. Every practicing obstetrician/gynecologist knows the fallibility of the patient's last menstrual period.

Patients will have what they consider to be a normal period when, indeed, it was not a normal period. In terms of the fact they may have already been pregnant. I think anybody who's been around long enough has seen a patient come into the hospital with abdominal pains, not realizing that she is a term pregnancy, who has had "regular periods" every month up until that point, and there is amazement at the fact that her abdominal pains are indeed a term pregnancy.

On the other side of the coin, one may skip periods, and the last menstrual period may have occurred at some relatively remote time in some physiologic terms from the actual conception of the fetus.

Q. Doctor, is there any test or method, other than the ones that you have described, which will tell you whether a particular fetus in the uterus is viable or not viable?

A. At the present time I know of only one other test, amnio-synthesis, for what we call the lecitthin/

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sphynogomyelin ratio.

These are two chemical compounds that are in the amneotic fluid, and their certain relationships to their concentration in terms of fetal viability.

However, in terms of this After, this would not be applicable, because these relationships do not usually determine viability until about the 34th or 36th week of pregnancy. Prior to that they would indicate immaturity of the fetus.

Q. Doctor, if you cannot then tell till after the 34th or 36th week whether or not a particular fetus is then

viable, are you able to express it in terms of some probability?

A. Yes, I believe we could.

Q. Can you relate those to weeks of gestation?

A. Yes. This is again open to different opinions. In my opinion, the average commencement of viability occurs at about 24-to-26 weeks' gestation, at the very earliest; and very, very few of the fetuses born at this stage of the pregnancy will survive. It is a matter of one or two percent.

I do not personally believe that a fetus born prior to 24 weeks' of gestation has any reasonable chance of survival.

Q. Doctor, what do you define as a "reasonable chance of survival"?

A. Well, in terms of this: I would like to think that a reasonable chance of survival is at least on terms of five percent, and even by any extropolation you may wish to use, certainly at least two to three percent.

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Q. Have there been reported cases of fetuses surviving at less than 24 weeks?

A. There have been reported cases. The smallest fetus I know of weighed 397 grams, which would have theoretically placed this fetus to about seventeen-to-eighteen weeks' gestation, if one used fetal weight as the sole arbitor of maturity.

* * * *

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Q. Doctor, I ask you to assume that you were instructed to determine, with respect to a given patient, at what point in a pregnancy the fetus might be viable.

I will instruct you, for the purpose of my question, the lower limit beyond which you can say with certainty a fetus was not viable where would you place that period of gestational age?

A. I would have to place it at approximately 24 weeks.

JUDGE ADAMS: Would that be 24 weeks from conception, or 24 weeks from the last menstrual period?

THE WITNESS: The last menstrual period, sir.

Q. Now, given the 24 weeks—

THE WITNESS: Based on an average 28-day cycle.

Q. Given the 24 weeks which you have expressed is your opinion at the lowest point at which the fetus might be viable, and allowing the margin of error you had previously described, what might be the lowest practically determined gestational period at which a fetus might be viable?

A. Well, you'd have to allow two, perhaps under difficult circumstances four weeks. So it could range anywhere say, from 20-to-28 weeks.

JUDGE ADAMS: You say it ranges anywhere from 20-to-28 weeks. That range might be further contingent on the facility present when the fetus is in the uterus.

In other words, where you have more facili-

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ties to support the fetus, you could have a slightly

lower time period, and when you have fewer facilities, you would have to have more?

THE WITNESS: Yes, sir.

Q. Now, Doctor, you have described for the Court your opinion, based on your qualifications, expensive as they are, with respect to viability.

Would you expect all physicians to agree with you on these definitions?

A. No.

Q. Are there medical differences of opinion which are respected differences of opinion?

A. Yes.

Q. Doctor, after approximately the middle of pregnancy, is it as easy and positive to tell the gestational period by the tests you have indicated, as it was during the early part of the pregnancy?

A. No. The further along the pregnancy goes, the more difficult it is as I indicated based on the eventual size of the fetus as determined by its genetic make-up.

In fact, and in part by the, shall we say, the uterine involvement that the fetus finds itself in.

Q. Doctor, at what gestational age would you, in your opinion, notwithstanding other respected medical opinions, would you believe that a fetus has a reasonable chance of survival?

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A. Twenty-four-to-twenty-six weeks at the earliest.

Q. Is that a fifty percent chance?

A. Oh, no, nothing like that. I can guarantee you a cross-the-board that you will not find any doctor who

will tell you that a twenty-four-to-twenty-six week fetus has a fifty percent survival chance.

That does not occur until about the 32nd week, give or take two weeks.

* * * *

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Q. And can you indicate for us, Doctor, what the preferential method is for the performing of second-trimester abortions?

A. By whom?

Q. By you.

A. Saline amnio-infusion.

Q. I detect from your answer some question with respect to the general consensus on this.

Can you describe to me whether there would or would not be disagreement on this?

A. There are differing opinions on this. There are new medications on this, called the prostaglandins, a family of 22 different compounds, of which two have been found useful in second trimester abortions.

These are administered by several routes: intravenously, intramuscularly, into the uterus, into the vagina, will produce abortions.

They do have certain safety factors over the saline.

The reason I do not personally happen to like them is they have side effects on the patient that frequently are uncomfortable.

Secondly, they—they are more likely to require repeated * * *

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Thirdly, in second trimester abortions, there is the much greater incidence of the possibility of the fetus being

born alive after a prostaglandins infusion, than there is with a saline.

Q. Doctor, if you were to conduct a procedure contemplating the delivery of the fetus, and you wished it to be delivered alive in 26 weeks, what procedure would you use?

A. If I were forced to this stage, I would say that I would probably have to try oxytosin induction, which I really no not expect to work at this stage of the game.

It can be forced to work. There is evidence that a very fine physician in Montevideo, in Uruguay, a Dr. Caldeyro Garcia, who has shown that almost anybody can be put into labor with a sufficient amount of oxytosin, over a sufficient period of time, sometimes utilizing very, very high dosages of the medicine than we would normally think of.

However, this can be a prolonged and expensive procedure for the patient. Usually, I would say at this stage of the game, we would usually go if the baby is viable we call it a Caesarian section; if the baby is not viable, we call it a hysterotomy.

Q. Doctor, is that procedure distinct and apart from the oxytosin procedure?

A. Yes, totally.

Q. Is it distinct or not?

A. Totally distinct.

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Q. Now, Doctor, what is a hysterotomy?

A. A hysterotomy is exactly the same as a Caesarian section; it is just being used when the fetus is nonviable.

A Caesarian section includes an incision in the abdomen to the uterus; the taking, generally, of the bladder of the interior wall of the uterus, entering the uterus, making an incision in the uterus, removing the products of conception in the uterus, sewing the uterus back up, reapproximating the bladder, and then closing up the abdominal wall.

Q. Remaining for the moment with hysterotomy, Doctor, could you give us the medical indication or contra-indication of it from the mother's standpoint?

A. Well, the indication for it would be, as I said, it is more immediate and less-expensive and time-consuming to the mother.

The contra-indication to it is that all future children born to this mother, in all probability have to undergo a Caesarian section.

It is open to differing medical opinion, but the great majority of the obstetricians in the country feel, basically, that once the endometril cavity, which is the inside of the uterus, has been entered surgically once, all deliveries thereafter should be done by Caesarian section, because of the possibility of rupture of this scar.

The earlier in pregnancy that you do this, the more likelihood that you are going to have to put the scar up into

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what we call the upper segment of the uterus—the fundus —where the scars are even more likely to rupture.

Q. Doctor, I am going to read to you a statement from a medical text for obstetricians, which I believe you are familiar with, and I am going to ask you whether they describe the general range within which the substantial

part of medical opinion falls with respect to the definition of "viability."

First, Doctor, would it be correct to state that interpretations of the word "viability" have varied between fetuses of 400 grams, about 20 weeks' gestation, and 1,000 grams, about 28 weeks' gestation?

A. Yes.

Q. Would it be correct to state that survival of a fetus under a hundred grams is unusual?

A. Yes.

Q. You have indicated that your particular definition of "viability", in terms of weeks of gestation, might be different by other physicians.

Are the differences in the entire medical community, physician-by-physician, in the application of the term "viability"?

A. I don't quite understand what you mean, sir.

Q. Apart from the fact that some physicians might disagree with your definition of "viability"—

A. Yes.

Q. (Continuing)—assuming a physician took a different

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position, would there be other physicians that disagreed with him?

A. Yes.

* * * *

Cross-Examination

BY MR. MANSMANN:

* * * *

Q. Doctor, at the close of your testimony on direct examination, you had indicated that there is a disagree-

ment among the medical community as to viability; is that correct?

A. Yes—well—yes.

Q. So that I understand it properly, you are saying there is disagreement as to the point of viability, or when a particular fetus may attain viability; is that correct?

A. Yes.

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Q. And not as to the standard definition of viability?

A. No. There is a disagreement, I would believe, as to the standard definition of viability.

Q. Where does that disagreement come in; can you tell me that?

A. Well, it would depend on which definition of viability you are using.

Q. How about your definition of viability?

A. Again, there would be differences of opinion; because some people might feel my definition of viability is not accurate.

Q. Now, your definition of viability fairly closely matches the standard definition of viability, doesn't it?

A. Yes. I do not believe I am an off-beat physician.

Q. And the definition that you have recited to this Court is fairly close to the definition that the Legislature has placed in the Pennsylvania Abortion Control Act; is that correct?

A. No.

Q. The only difference is the words "reasonable ancillary aids"; is that it?

A. Those are my words.

Q. Right.

A. Well, in part, because the Act puts no weeks' gestation on viability. It leaves the interpretation of "viability" up to whoever is interpreting the term "viability".

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Q. In other words, it leaves it up to whoever is interpreting "viability" is that correct?

A. That is correct; be that the physician or the prosecuting district attorney.

Q. I believe the Act says that a physician, based on his medical judgment and experience, determines viability; isn't that right?

A. Yes. But if a district attorney wanted to make a case, he can say that that physician's judgment is not valid.

Q. Right. This is where you are talking about having a potential conflict as to whether or not this particular child or fetus was viable?

A. That is correct.

Q. It is not that the Act, or the definition contained in the Act, is clear; is that right?

A. It is unclear, so it makes it difficult for me to make a medical decision on an unclear statement.

Q. And you had gone through with Mr. Morris what the standard definitions are; is that correct?

A. Yes.

Q. And the—one thing that bothers me, Doctor, is that you had previously stated that gestational age by itself could be misleading; is that correct?

A. Yes—well, gestational age based on what?

Q. Based on the clinical history you obtained from the patient and, perhaps, your own examination—physical examina-

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tion.

A. Yes, it still could be.

Q. If we had an Act that said 24 weeks' gestation, and that's the point of viability, wouldn't that be arbitrary?

A. Yes. But that can be ascertained more clearly by the presented data.

In other words, I would feel more comfortable with some fact like this, where I could state that the patient states here is her last period; the uterine size is such-and-so. This tends to conform more to a fact than a figure.

Now, those things have a reasonable margin of error, too. But they are less subject to error than another definition of viability, which was indicated anywheres from 400-to-1000 grams.

Q. Doctor, you can't use grams alone, can you, Doctor?

A. No. You can't determine that until the fetus is out of the uterus.

Q. And there are nutritional aspects that you have to be concerned about, perhaps, if the mother is a smoker —I am talking about a tobacco smoker—or if the mother had some malnutrition; that is going to have an affect in the baby she is carrying, isn't it?

A. That is correct.

Q. That is going to decrease the weight?

A. Yes, sir. This would be a small-for-date baby; one that is more mature than the size would indicate.

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Q. So, that small-for-date baby may be viable, although of a lower weight than a non-viable baby; is that correct?

A. Right.

* * * *

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Q. So in your report—not your report—the report of your committee, it stated that the majority of those who responded indicated that they would limit abortion to at least 20 weeks?

A. Yes.

Q. 160 members felt that abortion should be carried out—

A. Just a moment. 160, an overwhelming majority of what?

A. Of 197 who felt the abortion should be carried out in hospitals to insure patients' safety; is that correct?

A. Yes.

Q. They had—the Society would have entered gestational age of 20 weeks as the outside limit for abortion; is that correct?

A. I don't know that that necessarily would have been correct. This was just an opinion survey; this was not done for future guidelines.

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Redirect Examination

BY MR. MORRIS:

Q. Dr. Gerstley, do you have before you the questionnaire of the Obstetrical Society of Philadelphia, to which Mr. Mansmann referred to in cross-examination?

A. Yes.

Q. I direct your attention to Question 8. Would you read that into the record, please.

A. (Reading) "Who should regulate abortion practice?" is the question.

The answers were divided into three: "(a) State legislature," responses 20; (b) "Federal government," responses 24; (c) "Physicians or hospitals," responses 137.

* * * *

TESTIMONY OF JOHN FRANKLIN, M.D., TAKEN ON JANUARY 14, 1975

* * * *

(p. 7)

BY MR. MORRIS:

Q. Now, Doctor, you have heard the word "viability," have you not?

A. I have.

Q. Would it be fair, in general terms, to describe that as the ability of the fetus to survive outside the mother's womb?

A. Yes.

Q. Might some artificial aid be required in some cases?

A. It might well be to preserve the life of the fetus.

Q. If you are presented with a patient, can you determine whether or not the fetus in that patient is viable?

A. I cannot, in any absolute sense; only in a relative sense.

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I think the best thing I could do is offer some probability of the ability to survive outside the mother's womb.

Q. If the fetus is 16 weeks, could you make an absolute determination?

A. From my present knowledge of medical skills, I would believe no fetus of 16 weeks could survive outside the mother.

Q. What about by extraordinary means?

A. The fetus of 16 weeks has heart-beat, has the ability to attempt to survive. Extraordinary means might prolong the heart-beat. That may, in some opinions, be regarded as viability—but not in mine.

I would feel that the infant has the potential for growth at 16 weeks.

Q. Doctor, if you moved onto 24 weeks, a diagnosed 24-week gestation period, could you determine whether that fetus was or was not viable?

A. I could not.

Q. What is the probability?

A. The probability would be very high that the fetus was not viable.

Q. What would be the order of viability in 24 weeks?

A. It would be 95 percent that it is not viable.

Q. What about 28 weeks, Doctor?

A. Twenty eight weeks is a real probability.

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Q. Is respiration a controlling factor, Doctor?

A. To my knowledge, respiration is the key factor.

Q. Now, Doctor, you have indicated some probability. Would you expect a physician generally to agree with you?

A. I have found in reading opinions about viability that physicians do disagree.

Some physicians feel there is the same degree of life present from conception onward, which is the same as survival outside. I suspect there is disagreement about life in the fetus. There are specialists of neonatalogy that push back the time of gestation, where the infant can survive outside the mother.

I assume that will change as technical skills improve.

Q. Doctor, have you done some embryological experiments which are related to life and viability?

A. Yes. For two years I attempted to grow the rat embryo outside the mother, and came to the conclusion that I was prolonging the death of the rat embryo.

When these were looked over in the microscope, it was a slow dying process. I extended the life by 24-to-28 hours by artificial means, such as oxygen; but I did not feel that I was keeping the embryo alive.

Others were engaged in the same work to keep the rat embryo alive outside the uterus of the mother.

(p. 10)

Q. In the case of the presentation of the human fetus in the 20-to-30 week gestational area, would you expect to find some attempts to perform life for some period of time would be successful?

A. I would suspect that what I was involved in, the rat embryo, would be continued on a more sophisticated level, and the probability would be that it will survive for a long period of time, and this may be called by some artificial viability.

Q. Now, the Act under consideration before this Court provides, in part, in Section 5, that if a fetus may be viable then the method of delivery of method of abor-

tion used shou' be that method that provides the fetus with the best opportunity to survive.

Applying that requirement, what method of delivery would be compelled to be used?

MS. LEADBETTER: Objection, Your Honor. The Statute contains an additional caveat; that this method must be used if this is not dangerous to the mother.

I think that is a very important consideration in the case.

MR. MORRIS: I'd like to rephrase my question, if I may, Your Honor.

JUDGE ADAMS: You may.

(Section 5 of the Act read into the record.)

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I now ask you: what method is available if the fetus may be viable, which would give it the best chance for survival?

A. The best chance would be to turn the fetus, once outside the mother, over to those persons best able to maintain its existence.

The procedure to remove the fetus would be to use the hysterotomy method—the removal from the uterus, passing it over without exposure to gases, and so on, to neonatalogy or research workers, someone seeking to maintain the life of the fetus.

Q. Does a hysterotomy, in your opinion, suggest any medical complications for the mother and, if so, what are they?

A. The medical complications of hysterotomy are largely limited to a surgical procedure, Caesarian section, in which no labor has taken place.

Q. Are you familiar with the procedure involving oxytosin?

A. It is possible to simulate labor by drugs and deliver such a fetus vaginally. But the labor, in my opinion, would be a threat to the baby's existence, and the hysterotomy would maintain the existence of the baby, which is the primary role.

Q. If the determination that hysterotomy is detrimental to the life or health of the mother, in the sense it could not be used, would there be any procedure available which would give the fetus the best chance of survival?

(p. 12)

A. The hysterotomy, drug-induced labor, would be the best possible way to getting the baby with the heartbeat.

Q. In other words, your method of choice would be hysterotomy, under those circumstances?

A. That's right.

* * * *

BY MR. MANSMANN:

(p. 17)

Q. Now, Doctor, you also said yo: expect other physicians to disagree as to when a particular fetus has attained viability; is that correct?

A. The definition appears logical, but the application appears different.

Q. Your complaint is that there is a potential disagreement among physicians concerning the application of this particular provision of the Act?

A. The lawsuit in Boston is a case in point; physicians disagree about the viability of 21-to-24 week fetuses.

Q. Twenty four-week fetuses you gave a 5 percent chance of survival; is that correct?

A. Yes. I think that is optimistic.

Q. You set viability at 28 weeks?

A. Yes.

Q. I assume, as the gestational age increases and the weight increases, there is a better chance of survival?

A. Yes.

Q. And this is based on your experience?

A. This is based on tables compiled on the 28-week fetus, judged by others at other institutions.

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Q. So perhaps one 26-week fetus will not be viable and another 26-week fetus perhaps would be viable?

A. That's right.

Q. So that is why you have to judge each case individually?

A. That's right. We cannot judge prior to delivery except to arrive at some probability that I believe the mother is 26 or 28 or 24 weeks.

Q. I think this is some area of confusion. You have talked about disagreement, philosophical disagreement, as to when life begins.

A. Yes.

Q. So some physicians think life begins at conception and others think it begins at delivery?

A. (Indicating)

Q. And some perhaps—

MR. MORRIS: You will have to answer orally, Doctor.

A. Yes.

Q. And some think life begins after the neonatal period of 28 days; is that right?

A. I am not aware of anyone maintaining that definition.

Q. So that life and viabiliy are two different things; you do agree?

A. I agree.

Q. While there may be potential life from conception forward,

(p. 19)

do you agree that there is a point in which viability is reached prior to delivery?

A. I agree with that.

Q. And that there is a definition between viability and life?

A. I agree with that.

Q. The philosophical inferences you were talking about were relating to life rather than viability?

A. I agree with that.

* * * *

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BY MS. LEADBETTER:

Q. Dr. Franklin, let me see if I understand what you have said so far in one area: You have said that at the point of 28 weeks you would consider a fetus normally to be viable; is that correct?

A. That is right, that it has a reasonable chance of survival.

Q. Prior to 24 weeks you would not consider it to be at all viable; is that correct?

A. It all implies probability; a very high probability it will not survive.

Q. In the period between 24 and 28 weeks you have a gray area where the fetus may be viable, depending on different circum-

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stances?

A. That is correct.

MR. MORRIS: I object to that phrasing of the question. I don't think that is what the witness said.

JUDGE ADAMS: Sustained. That was not the testimony.

Rephrase the question.

MS. LEADBETTER: All right.

BY MRS. LEADBETTER:

Q. And there is some increasing degree of viability or survival of the fetus in that area, between 24 and 28 weeks; is that what you said?

A. That is my impression.

Q. Concentrating on this period between 24 and 28 weeks that you have delineated for us, you have said that the greatest likelihood to preserve fetal life would be hysterotomy; is that correct?

A. That is correct.

Q. What method of anesthesia would you use on the mother for the hysterotomy?

A. It probably makes little difference as to which

type of anesthesia is going to be used, based on what I know.

I have not been in the situation, so it is purely hypothetical.

Q. Ordinarily, with a hysterotomy procedure you use a general

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anesthesia rather than local?

A. There are alternatives to those two choices: regional anesthesia in the form of spinal or epidural is another alternative.

Q. If you did not use a general anesthesia, that would reduce the risk of the procedure; wouldn't it?

A. I have no data for concluding this. It might seem so on a theoretical basis; but I know of no data.

Q. Now, is it possible for you to quantify generally the difference in the risk to the fetus of hysterotomy procedure and the procedure using a combination of prostaglandins and oxytocins?

A. No. I have almost no experience with trying to induce labor at that stage with oxytocin.

The literature says it is difficult and may take several days. The claims with prostaglandins are that they are more effective so that you can reduce days to hours, 48 to 72 hours.

I have had no experience with these, with the use of prostaglandins.

Q. So you have no experience with this procedure at all?

A. With attempting to induce an abortion by oxytocin or prostaglandins.

The usual procedure of inducing abortion around 24 weeks is to use saline, saline salt, which is fatal

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to the fetus.

Q. But the method of prostaglandins is beginning to be used?

A. Nowhere near the frequency that saline is used, in my opinion.

Q. That is not my question. It is beginning to be used?

A. That is correct.

Q. And although the replacement of amnionic fluid with the saline solution will almost certainly kill the baby, the infusion of prostaglandins will not have that effect?

A. I have no information on what the—how many of those fetuses would be born without a heartbeat.

Q. That is not my question.

My question is, prostaglandins stimulate uterine contraction rather than kill the child; is that correct?

A. That is correct.

Q. You have testified that the method of hysterotomy has certain effects on the mother, including the necessity for future Caesarian births if the mother wishes to have a child at some future date; is that correct?

A. That is not an absolutely necessity, but it might be considered by many physicians to be the safer route of delivery.

Q. Now, including the probability that future childbirths will be by Caesarian, can you tell us the additional risk to maternal health by using the hysterotomy procedure rather than a saline or prostaglandin induced vaginal abortion?

(p. 28)

A. Not in terms of mortality figures. The risk is not great.

Q. My question, Dr. Franklin, is not as to risk of death of the mother, but as to the preservation of health of the mother.

A. The risk to the mother's health is not great.

Q. You are saying that the risk of health to the mother in the hysterotomy procedure is not great?

A. That's right.

* * * *

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BY MR. MORRIS:

Q. Dr. Franklin, are there reputable and respected physicians who would be of the opinion that a 21-week fetus delivered by a hysterotomy might be viable?

A. I believe there are.

* * * *

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BY MR. MORRIS:

Q. Doctor, is there a possibility of such testimony or probability of physicians so testifying a probability which might inhibit your conduct?

A. Yes, indeed.

MR. MORRIS: That's all, sir. Thank you.

Recross-Examination

BY MR. MANSMANN:

Q. Doctor, you have never done a prostaglandin abortion; is that correct?

A. That is correct.

Q. You really don't know that much about them; is that correct?

A. That's right.

Q. But you do know they are not as life threatening to the

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woman as a saline abortion, for example?—life threatening.

A. To the mother?

Q. Right.

A. Yes. I would answer that is true.

Q. They are not life threatening?

A. They are less life threatening than a saline abortion.

Q. You have been concerned about other physicians apparently testifying against you or some other physician. Who are the physicians that you are concerned about testifying against you?

A. I am not sure I understand the question.

Q. You said that you know that there are reputable physicians who would have a differing opinion from you, and your concern is that they may testify against not you necessarily but some other physician who performed an abortion on a 23, 24-week, 21-week fetus.

A. That's right.

Q. Can you tell me who they are?

A. Not by name. I cannot tell you physicians by name or even category. I know that there are physicians who are outspoken on this subject.

The most recent concrete example I can give you is that recently there was a neonatologist in the City of Philadelphia who felt that the task was to try to maintain the

existence of a 20 or 22 or 24-week fetus, no expense spared, with whatever techniques known to medicine.

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Q. That is his responsibility, the care of the premature or immature infant; is that correct?

A. That's right. But I believe that some neonatologists may pursue their duty of care to limit it to those infants where there is a good probability of a normal existence later, that they might make some choices as to which fetuses or infants they are going to pursue with the most concern.

Q. Can you tell me then their names again, please, the neonatologists that you are concerned about?

A. Yes. The physician who I believe would have sought to maintain the life of a very young fetus was Dr. Mary Louise Soengten.

Q. Now, you are saying that you attempt to maintain life of a premature—

A. Immature is the word I would use.

Q. —immature fetus; is that correct?

A. That's right.

Q. And her specialty is neonatology?

A. That's right.

Q. So I understand you properly, if a 21-week baby is delivered or a live birth resulting from an abortion, she would have the responsibility of attempting to keep this child alive; is that right?

MR. MORRIS: I am going to object. I think in getting to what she would do we are getting a little

(p. 33)

speculative.

The thrust of my questioning involved what his mental and psychological concerns were with respect to what generally might happen. If we are acting with respect to one doctor, I think we are a bit speculative as to this witness.

BY JUDGE ADAMS:

Q. Do you have any knowledge as to what this physician would do or might do? Do you know enough about her professional operations to express an opinion?

A. I worked with this neonatologist for three years. So I have some knowledge.

JUDGE ADAMS: We will allow the question if he can answer it.

BY MR. MANSMANN:

Q. You are saying that she would attempt to use all efforts to keep this child alive?

A. Yes.

Q. And that is her profession?

A. That is how she saw her responsibility, as I understand it from observing her.

Q. So that your concern is that she would come in and testify against a physician; is that right?

A. As I understand what we are talking about, the statute says that you have to do the procedure that gives the fetus the best chance of survival.

(p. 34)

Such a person as Dr. Soengten, could in my opinion, be willing to say that a saline procedure was not the right

procedure for the termination of that pregnancy, and that she would like to have a 20 or 21-week fetus try to maintain its life. And that might be how she saw her task as a neonatologist.

Q. So that it is her discharging of her professional responsibility as a neonatologist which color her opinion; is that what you are saying?

A. That is how she saw her responsibility as a neonatologist, to not have an arbitrary decision that we would not try to save a baby younger than 24 weeks, but to try to save anything that might be saved, that this is the way the barriers will be raised or lowered—I guess lowered for maintaining or saving the lives of very young immature babies.

Q. It is not your opinion that you as a physician or Dr. Soengten should attempt to save the life of the child who can be saved?

A. I didn't say that. My opinion is that if the woman is seeking a termination of a pregnancy that I should be permitted to terminate her pregnancy.

I should not be required by the State of Pennsylvania to do an operation and to spend vast sums of money in the pursuit of trying to maintain the existence of an immature fetus.

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Q. So it is the vast sum of money, is that your concern?

A. It certainly enters into it.

MR. MANSMANN: That's all I have.

BY MS. LEADBETTER:

Q. Doctor, you wouldn't go to that extent and spend those vast sums of money you were talking about to save

the life of a 20-week fetus who was spontaneously aborted as the mother wanted, would you?

A. Would I?

Q. Yes.

A. This is a decision that comes up quite often in my practice and experience. I find it very difficult.

Q. Have you ever done that?

A. Yes, indeed.

Q. Spent vast sums of money to save—

A. No. I have sent immature fetuses to the neonatologist saying this is a desired pregnancy, the mother has passed the fetus and she was hopeful of carrying it, and the fetus has a heartbeat for several hours.

Q. Has one of those fetuses ever survived?

A. Not to my knowledge.

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TESTIMONY OF FRED MECKLENBURG, M.D.,
TAKEN JANUARY 14, 1975

* * * *

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BY MR. MANSMANN:

Q. Doctor, would you explain to the Court what another method of abortion is which is known as a D&C?

First of all, what do those initials stand for?

A. The term D&C refers to dilation of the cervix and curettage, which is a French word meaning to scrape. Both terms are French.

It applies in abortion to the situation when the uterus is forcibly opened by stretching it and gradually inserting increasing size metal instrument, called a curet introduced—

Q. Could you describe what a curet is?

A. A curet is a loop shaped instrument with a sharp edge that is used like a hoe might be used to loosen the soil of a garden. It is used to scrape the lining and contents of the uterus out.

A more popular method of this at the same point involves using suction rather than curets.

Q. Is the same procedure utilized at least initially in a suction abortion as would be in a D&C as you have previously

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described?

A. Yes. The dilators are used identically the same. The mouth of the uterus is forcibly opened by passing larger dilators. Instead of introducing the curet a larger diameter tube is introduced, and a very powerful suction amounting to several times the atmosphere of the earth is used. This disrupts the pregnancy, usually reducing the content at this early stage. It is reduced to the consistency of crankcase oil.

Q. This is done through the evacuation machinery; is that correct?

A. Right. It is simply the exposure of the very intense pressure that does this.

Most doctors who use suction as a means of abortion also use a curet to be sure that the tissue has all been removed.

(p. 40)

BY MR. MANSMANN:

Q. Doctor, what was the reason where there would be concern that all the placenta tissue has been removed?

A. In most cases all tissues not removed, there is an increased risk of hemorrhage to the woman.

Q. Doctor, we have heard some testimony about an abortion called a "saline-infusion" abortion. Would you please explain that procedure?

A. A saline-infusion abortion is usually used later in the pregnancy, whereby a needle is inserted through the mother's abdominal wall and into the uterus, and a quantity of the amniotic fluid is generally removed for safety reasons.

Q. What would be the danger of injecting more fluid than that which is removed?

A. If the concentrated saline is removed without amniotic fluid, it increases the chance for hemorrhaging. This solution would escape through the abdominal wall of the woman, and it is important to remove the fluid, at least as much as you intend to inject of the saline.

Q. How is the abortion performed, or how would the saline-infusion effectuate or cause abortion?

A. That is something that is not clearly understood. We do know for sure that the saline almost invariably kills the baby.

Most mothers report the traumatic thrashing about and increased movement of the child, and then there is

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movement. We think what happens is that there is a very delicate shift of sodium ions from within the cells of the uterus to extracellular space. In that case the uterus begins to be irritable and starts to crack.

Q. Is the fetus then expelled immediately?

A. Generally there is a latent period. It varies from patient to patient.

Usually the latent period would be twelve to twenty-four hours. When labor does start it is generally fairly rapid, and generally less painful than one would expect.

Q. Would that be a period of 48 hours before the fetus is expelled?

A. 48 hours, yes.

Q. That would be, obviously, vaginally?

A. Yes.

Q. Would that be the simulated type of delivery, had the woman carried to term?

A. There is some experience that would suggest, although not exactly, the same as actual labor. There very often numerous cases report it following the saline infusion, that the cervix had failed to dilate, and the woman seemed to be in natural labor, but in some ways different.

Q. There is, Doctor, another procedure called the prostaglandin infusion. Is it similar to the saline infusion?

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A. In several different ways, yes.

Q. Will you tell the Court in which ways, Doctor?

A. They can be given to the patient intravenously. Very high incidents of severe headaches, diarrhea, nausea occurs, and also the uterus dilates and also results in the expulsion. Few people are using it that way.

It can also go directly into the uterus. It works in a similar fashion, except that it does not kill the baby. The side effects seem to be less severe, but similar. That is, headaches, nausea and vomiting do occur, but with less severity. That is called extra-embryotic. This is similar to the saline infusion, but in many ways it is different.

Q. Doctor, you talked about side effects. Are there side effects in the saline abortion?

A. Yes. There are very big ones. This has been a great deal of concern to many of us. The clotting mechanism of the person in a saline abortion is influenced 100 percent of the time.

In saline abortions, many of these women don't hemorrhage. The clot mechanism is interfered with. Some of these are very severe, and deaths have occurred. If the saline ends up getting into the mother's bloodstream or outside the uterus into the mother's abdominal wall, each of these are hazardous and lives have been lost because of this.

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Q. Doctor, are there side effects similar to the prostaglandin effects you described in the saline abortion?

A. No. We don't see the nausea, headaches, diarrhea and vomiting.

Q. So that the side effects you are talking about is associated with prostaglandin, the headaches?

A. The heart rate and the blood pressure; they are all side effects of prostaglandin.

At a conference of the American Association of Planned Parenthood, in Kansas City, Dr. Bengston discussed the sum total of side effects as being physiological. He was very apprehensive about the total body organization.

Q. Doctor, you are a member of the Association of the Planned Parenthood Physicians; is that correct?

A. Yes, I am.

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Q. And another procedure, would that be the hysterotomy procedure?

A. Yes.

Q. Would you describe that for the Court, please?

A. Well, as Dr. Franklin described it a short time ago, it is a miniature Caesarean section. It involves a regional or general anesthetic; it involves an incision in the abdominal wall, and the fetus is then removed from the mother's placenta, and it is then repaired in the same manner as the Caesarean section.

Q. Could you tell the Court in which gestational age these particular abortions are normally utilized?

A. Only very early in pregnancy, those people that described the procedure in the literature, suggested that it never be used after the patient is 8 weeks from the first day of the last menstrual period, and 6 weeks from conception.

It usually would be confined to patients who are 7 weeks or less.

Q. How about a D & C or dilation and evacuation?

A. Either of these procedures can be used up to 12 weeks.

Q. Are you talking about 8-to-12 weeks?

A. Yes. There are very few doctors that want to do it between 8 and 12 weeks.

Q. Can you tell us the reason for that, Doctor?

A. Well, it is hard to do it with safety, and it is difficult

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to do a D & C or a D & E.

Q. Why?

A. Well, the baby is getting large enough for the skeletal system to form. The skeleton is getting dense enough for the bones to start forming, and it involves a

considerable hazard to try and extract bone from the mother's womb.

Q. Between the 12th and 16th week of gestation, generally there would not be abortion performed?

A. Those doctors that utilize prostaglandins use them during this period mostly. Doctors would prefer not to do it during the period from 12-to-16 weeks.

Q. Now, after 16 weeks, what method is used, Doctor?

A. It can be used after it is safe to get into the amniotic cast. Doctors that do late abortions do utilize saline.

Doctors after 20 weeks are reluctant to use saline. Most of us that do any significant number of deliveries are reluctant to do it. The hysterotomy then enters where the doctor is concerned for the safety of a viable child.

There are patients where saline is very risky. The patient might have had extensive abdominal surgery, and it would cause excessive bleeding in these patients. In these cases, the fetus might be extracted by hysterotomy rather than saline.

Q. The hysterotomy might be used in generally what gestational age?

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A. Probably in common practice, after 24 weeks.

Q. After 24 weeks on?

A. Yes.

Q. In some point that becomes a C-section, and is no longer designated a hysterotomy?

A. Technically, it's a C-section; but all along it is the procedure when it is called a hysterotomy.

Q. Doctor Franklin called it a miniature C-section. He was accurate, in other words?

A. Yes.

Q. Can you tell us what risks are inherent in the various procedures; the risks to the woman undergoing the abortion? Let us take menstrual extraction.

A. That is classified into two general areas: infection and hemorrhage.

Both of these are most often associated with incomplete evacuation of the uterus. There is a possibility that it would push bacteria into the uterine area where infection can ensue.

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Q. The safest period, as far as maternal health is concerned, would be what gestational age?

A. To break it down, during the first 8 to 9 weeks is the safest time.

Q. Would you put 8 to 12 weeks?

A. Most doctors like to work from the 8th to 12th week.

Q. This is where the D & C or D & E are concerned?

A. Yes.

Q. What risks are inherent as far as the D & C is concerned?

A. The risks of perforating the uterus, or damaging the uterus, and the pregnant uterus is quite soft.

The second risk is the risk of hemorrhage; and the third is the risk of infection.

The data on complications does seem to vary according to the skill and experience of the operator. It varies not only from institution to institution within the United States, but more significant is the experience in this country to the experience of other countries. I am disturbed by the difference.

Q. What risks are inherent in the saline infusion, the risks to the maternal health?

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A. The damage would be that the bowel would be perforated; the risk of hemorrhage would be great, of lacerating vital areas; there is the risk of infection, where the needle might introduce bacteria.

The risk of the saline getting out of the uterus into the peritoneal gland causing saline intoxication.

Q. What would the effect be?

A. Besides overwhelming thirst, the person would become comatose. If the salt gets into the blood cell, it can cause hemolysis of the blood.

I think the principal risk of the saline abortion is the effect it has on the blood-clotting.

Q. Now, Doctor, you described that as one of the side effects; is that correct?

A. Yes; and also the risk of injury to the cervix causing the laceration.

Q. The saline-infusion abortion, is that a life-threatening procedure to the mother?

A. Yes, it can be.

Q. For the reasons that you have previously described about the installation of the saline solution into the maternal system rather than the fetal system?

A. I again refer to the material which was sumitted, where there were six deaths, but one occurred in the late trimester; three were associated with saline and three with hysterotomy.

(p. 50)

Q. And the hysterotomy, are there risks attendant in undergoing hysterotomy?

A. There are risks attendant to any operative procedure that involves anesthesia and incising the tissue.

Q. Would these be the same risks involved in any type of procedure?

A. Yes.

Q. Is general anesthesia administered?

A. It varies from hospital to hospital. It is usually regional and general anesthesia, depending upon the mother's health.

Q. Is saline infusion usually done with a local or general anesthesia?

A. It is generally one wheel of skin injected with novocain.

Q. There would be no general anesthetic given?

A. No.

Q. What about prostaglandin?

A. If it's prostaglandin the small area of skin is injected with novocain.

Q. What about if it is injected vaginally?

A. In that case no anesthesia at all.

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BY MR. MORRIS:

Q. Doctor, would it be fair to say that it is or a doctor about to treat a woman who is pregnant in the 20th to 28th-week period is a very difficult if not impossible determination to make to decide whether or not the fetus within that woman is or may be viable?

A. It is very difficult.

Q. Almost impossible, is it not?

A. Again, it is—there are probabilities. You can feel by examining the patient within a matter of three to four weeks what the state of gestation is.

Q. From that a lack of probability or probability of survival?

A. Yes.

Q. But impossible as to the specific fetus involved?

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A. That is correct.

In fact, I would agree with Dr. Franklin's testimony in that regard.

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BY MR. MORRIS:

Q. Doc , as one who performs abortions I want to read you a sentence and ask you what it means to you. The sentence is, "Viability means capability of a fetus to live outside the woman's womb albeit with artificial aid."

I want to ask you at what stage of gestation you as one who has performed abortions would put that definition?

MR. MANSMANN: I have to object and ask that be qualified as to whether or not he thinks that the doctor testified he performed abortions.

MR. MORRIS: I am not assuming he does it for whatever reasons he believes just. I want to ask him what viability means to him in terms of aid.

A. I would agree with that definition of viability. I think that it has been current. I think it is a definition that takes into account medical progress, the fact that it is constantly changing.

My perusal of the medical literature would lead me to believe that potential or continued life exists as early as 20 weeks—not in the current edition of Eastman's Obstetrics book, but in the previous edition, the earliest report a survivor was reported as a delivery at 20 weeks

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gestation.

In my own experience I have—the earliest survival that I have had is a patient who was 21 weeks from the time of conception or 23 weeks from the first day of her last menstrual period. The child is a year and a half old and normal.

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TESTIMONY OF DR. HOPE PUNNETT, TAKEN JANUARY 14, 1975

(p. 85)

MS. WALLIS: Dr. Punnett, please.

MR. MANSMANN: Your Honor, before we begin I request from plaintiffs' counsel an offer of proof as to this particular witness.

JUDGE ADAMS: Yes. Do you mind telling counsel what you hope to prove through this witness?

MS. WALLIS: Your Honor, we hope to prove by this witness that genetic counseling which, in some cases, involves abortion that has to be done between the 20th and 24th weeks of gestation, and consequently an interpretation of the state statute which would prohibit abortion after 20 weeks would foreclose this option.

JUDGE ADAMS: Do you object?

MR. MANSMANN: Yes, Your Honor. I don't believe that there is any evidence admitted that would place the child at 20-to-24 weeks.

There has been some testimony by the plaintiff that viability may occur at 24 weeks, and that was by Dr. Gerstley.

If that is so, the United States Supreme Court

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this Court from considering that. From the point of viability onward, the State has a compelling interest to prohibit abortion.

It would be legally inappropriate for this Court to make a consideration of that issue.

I do question the witness's ability to testify as to whether or not the abortion can be performed.

JUDGE ADAMS: We will deny the objection at this time.

We will give you the option to move to strike at the appropriate time.

MR. MANSMANN: Yes, sir.

DR. HOPE PUNNETT, called as a witness in behalf of the plaintiffs herein, after first being duly sworn by the Clerk of the Court, testified as follows:

Direct Examination

BY MISS WALLIS:

Q. Dr. Punnett, your qualifications have already been offered.

Is the resume you gave me still current; have there been any changes?

A. No.

Q. In addition to teaching at Temple University, you are also at Saint Christopher's Hospital; is that correct?

A. Yes.

Q. What are your responbilities there?

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A. I am head of the division of genetics within the hospital, the running of the laboratory for testing of certain genetic diseases; for seeing and examining patients for possible and known genetic diseases; for counseling the parents as to any known genetic diseases they may question in themselves, relatives or other off-spring.

Q. Now, Dr. Punnett, would you please describe genetic counseling?

A. It is a communication process whereby we not only give the specific scientific facts as to any individual concerned about a disease, but offer them the many different ways we can be of service, whether it be the placing of a child or discussing the various options that are open to them in relationship to their possible appropriation.

Q. Now, Dr. Punnett, I am showing you a publication called "Birth Defects," reprint series. Will you identify it, please?

(Handing pamphlet to witness.)

A. This is a scientific study published in 1970. The basic facts in it are a discussion as to how prenatal diagnoses are carried; the early studies and discussion of ge-

netic diseases that could be or have been diagnosed prenatally.

Q. Dr. Punnett, there is some handwritten notes in this exhibit. Could you identify those notes, please?

A. Those were my notes which were in an attempt to keep the article up to date and current with scientific knowledge.

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Q. Is the information in that exhibit correct?

A. Yes. There may be some places where causes of disease were not known but since have been known diseases, which were theoretically diagnosable, and the knowledge was not forthcoming at the time the article was written.

MS. WALLIS: Your Honor, I move into evidence this exhibit.

JUDGE ADAMS: Any objections?

MS. LEADBETTER: I have not had a chance to see the document, Your Honor.

JUDGE ADAMS: Then you will reserve any objection you may have to the exhibit.

MS. LEADBETTER: Yes, Your Honor.

MR. MANSMANN: I have no objection to the witness testifying, or this exhibit going into evidence with this caveat: that this should be treated as every other medical text we have submitted to the Court.

However, we are not agreeing to the truthfulness of the items submitted in that document.

JUDGE ADAMS: If you wish an opportunity to look at it, we will give you that opportunity.

MS. LEADBETTER: Thank you, Your Honor.

JUDGE GREEN: I am trying to determine what Exhibit 6 would be.

MR. MORRIS: Your Honor, Exhibit 6, which I

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marked, is a booklet in which appeared articles by a Dr. Meklenburg and Dr. Kravin, among others. I have not yet offered it.

JUDGE ADAMS: For what purpose are you offering Exhibit 7?

MS. WALLIS: For the purpose, Your Honor, of guiding Dr. Punnett's testimony.

The exhibit sets out the basic conditions and type of conditions that can be identified through genetic counseling.

JUDGE ADAMS: When you use it, you understand there was one objection being held in abeyance.

MS. WALLIS: Yes, Your Honor.

(Pamphlet marked Plaintiffs' Exhibit 7.)

BY MS. WALLIS:

Q. Doctor, would you give us examples of the type of genetic disorders that would be diagnosed?

A. There are two good examples, and they are probably tay-sachs disease. This is an auto-somal disease.

This means that two perfectly normal parents are each carriers of a gene for normal development of a particular enzyme; and also a gene that does not act at all.

The children that would come from these parents are born perfect children, and then six months after they are born they begin deteriorating. By the age of three

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they have lost all function; they can't feed themselves. In effect, they become a vegetable.

Then they are put into custodial care between that time and the time they die. It is now possible to recognize that two individuals married to each other who can have such a child.

When that is known, amniotic fluid in this case is simply removed, and nothing is replaced. That fluid can then be grown. There are cells which come from the fetus.

When enough cells are grown these can be analyzed to find out whether the child is lacking the enzyme. If the child is lacking the enzyme it is doomed to death before he is 7 or 8 years old.

In cases like that that child can be aborted from the mother at this point in the pregnancy, and the parents and the child are saved the agony of a slow and painful death, which is an unbelievable trauma for anybody connected with such a child.

Another example is one due to a chromosomial defect, Down's syndrome. Mongolism is one example of this.

Women over the age of 38 have a high risk of having Down's syndrome. Usually these families are identified after the birth of the first defective child.

Prenatal diagnosis is carried out in the same way. Chromosomes rather than enzymes are defective in these

(p. 91)

cases.

Q. Dr. Punnett, with respect to your description of tay-sachs, can you explain in great detail how couples who would be carriers of this disease could be identified?

A. This disease—let me backtrack. The gene that causes this disease happens to be present in a higher concentration of persons of the Jewish faith from Eastern Europe.

There is voluntary screening of this. Couples that might be concerned, they can go to a clinic and have their blood analyzed. Individuals who are carriers of the disease would have one normal gene and one abnormal gene.

Biochemically we can separate three classes of people: people with two normal genes; people with one, and people with no normal genes for that particular enzyme.

It is possible to recognize individuals who are carriers, simply by screening that population before they have a defective child.

Q. What would the extent of the risks be in a couple having a defective child, as a result of the pregnancy?

A. If both are carriers, the pregnancy carries a 25 percent chance of this child having a disorder.

Q. What are the options?

A. The couple can elect to have no further children. Some families went on and rejected the advice of having no further children, and decided to have children regardless of

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the consequences to the child.

Other families monitored the pregnancy, and had the defective child aborted.

Some families will also accept artificial insemination. In the case of artificial insemination, where the sperm donor does not have defective genes, the mother will have a chance of having normal children.

Q. Doctor Punnett, does part of your experience include the counseling of such couples?

A. That's correct.

Q. What do you tell these couples in a counseling session?

A. We explain to them scientifically on whatever level they are familiar with, the diseases and how it affects their child; how it could affect the child if they have one.

We would explain to them how it is inherited; why it is that two perfectly normal people can have an abnormal child.

Then we explain each of the options open to them. If the wife is not pregnant, we tell them whatever they decide to do we are always there to give them help and advice and keep them up with new developments.

If the woman is pregnant and wants to go through the term, we will help them through the termination with testing, or whatever it is they desire.

Q. Where the couple decides on an abortion, what would the

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time table be?

A. As we pointed out this morning, the same conditions hold for abortion.

It is not feasible to get embryonic enzymes under 16 weeks, because the uterus is not large enough at that time.

Q. Are you referring to the actual word, gestation?

A. Sixteen-week gestation, or 18 weeks after the last menstrual period.

Also, the cells do not grow as easily as the cells obtained from the menstrual period. The embryonic fluid contains a variety of cells, only a small fraction of which actually grow.

We take the cells from the embryo and we put them in a flask, then put them in an incubator, and hope they grow. If they grow, it will take two to six weeks for the test to be concluded. The way the cells grow there are a number of variables that enter.

The cells could be tested for the enzyme, for the chromosomes, or whatever it is we are diagnosing. It would then be communicated to the family; the family would discuss it and, if necessary, we make the arrangements for the termination of the pregnancy.

Q. What period of gestation would be the earliest?

A. With luck, one would have the results on the chromosome

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analysis by the time the tap is done. It might be four weeks before one would have sufficient evidence.

JUDGE ADAMS: If you added the two weeks and four weeks that you mentioned to the 16 weeks you previously mentioned—you indicated the time for testing was not ripe until the 16-week period—you are saying the cycle of gestation is 18 to 20 weeks?

THE WITNESS: Yes, sir.

JUDGE ADAMS: And the menstrual period another two weeks?

THE WITNESS: Yes. I know that is nerve-wracking for the person growing the cells and for the family.

Occasionally, the cells do not grow and we don't know this for a week or ten days. The obstetrician would go back and do a second embryotic tap, and we hope the cells would then grow.

BY MS. WALLIS:

Q. Dr. Punnett, does Saint Christopher's Hospital perform abortions at all?

A. No. We have no maternity service in the hospital whatever. We see patients referred to us by their own obstetrician, and patients that come to us because of their children diagnosed at the hospital.

Q. In these cases you would be seen by the family who elected abortion and diagnostic procedure, where would it be?

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A. It might be at any one of the number of different hospitals, depending on the patient's own obstetrician.

It might also be a patient who has come to us, whose obstetrician is not skilled in doing taps. We might refer that patient to Episcopal Hospital and Temple Hospital.

Q. Through your work you become acquainted with the policies in various hospitals in the City of Philadelphia, with respect to abortion under these circumstances?

A. That's correct.

Q. Now, we have heard testimony earlier making a cut-off point of 20 weeks with respect to abortion.

Is it your experience that that cut-off period applies to genetic counseling services?

A. It is my understanding that once a study has been initiated at 16 weeks—it is my experience that the genetic counseling services will see the family through to the logical conclusion, if that is concluded within a reasonable time span.

I can't say with any more certainty than that. I don't know about any other institutions; I only know about my own patients. You can't keep a family waiting 20 weeks, and then tell them, "Sorry, we don't know."

Q. Have you had experience with Philadelphia hospitals in performing abortions in situations where you have been personally involved in the situation after 20-week gestation?

A. I know of one where I have been involved.

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Q. How would an absolute cut-off point of 20 weeks affect genetic counseling?

A. It would be very, very difficult. One cannot guarantee a family that we will have a result by a magic date.

Sometimes this takes six weeks to get an answer. One cannot do genetic counseling if you cannot follow it to a logical conclusion.

A family will seek other means if at the end of the 20 weeks we still don't have the answer. They may terminate the pregnancy in what would have been a normal baby; or they may carry it through with this awful agony hanging over their heads.

It's a small number of families, but the personal agony to them is awful. If you have seen a child die of

tay-sachs disease, it is not something you wish on any couple, particularly the other children in the family.

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Cross-Examination

BY MR. MANSMANN:

Q. Dr. Punnett, is that the correct pronunciation?

A. Yes.

Q. You have described what I understand is an extremely dramatic and horrendous burden on any family to undergo. You described particularly the Tay-Sachs, which is extremely difficult for the parents and for the child infected with this particular disease. You have said that science has been able to pre-determine who is going to be a carrier, a potential carrier, of this particular disease; is that right?

A. We are able to determine who is a carrier, that is correct.

Q. Who is a carrier?

A. Yes.

Q. And you gave the percentage of 25 percent if both members of the marriage are carriers?

A. That is correct.

Q. What if just one is a carrier?

A. Then there is no risk to the child.

Q. Do you have any idea of the number that is involved, percentagewise, who would be carriers and of the potential of producing such a child?

A. Approximately one in every 15 individuals who is a Jew from Eastern Europe is a carrier of that disorder. This means that the probability of two such

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people marrying is 115 times 115. At any rate, one in several hundred matings would produce an affected child. That is in that particular limited population, Eastern European Jews. The disease is seen in every population in the world, but it is about 100 times rarer. We have seen it in non-Jewish families, black families, Amish families.

Nobody would suggest screening the whole population because it is too rare.

Q. Now we are trying to get an idea of the area that you service, the number of couples you have seen.

A. We do a very small number of screenings because there is a major Tay-Sachs program in the City which is run out of Jefferson Hospital. We don't do general screening. We only do family studies when a family comes to us with an affected child.

Q. Do you have any information as to the approximate number that would go to the screening, is what I am asking?

A. Well, the aim is every Jewish family in this area.

Q. Would go through the screening?

A. To go through the screening. Every family whose parents come from Eastern Europe is at risk.

Q. Do you know how many are found to be—

A. Of that 115 times 115, that is based on the statistics of screening in the number of cities in the United States and Canada that one out of every 15 just from Europe is a carrier.

(p. 99)

Q. Do you know approximately how many, say, in the Philadelphia area, for example, that you would be

familiar with, the number who have this potential problem?

A. I don't know what the Jewish population of the Philadelphia area is; I am sorry.

Q. You do not know what the potential number or probable number would be? If you don't, say so.

A. No, I don't know what the Jewish population of Philadelphia is.

Q. You have recited to us a history of one family who you counseled who decided to have the pregnancy terminated; is that right?—after 20 weeks?

A. No. Actually it was a different genetic disease which I mentioned that I know was terminated after 20 weeks.

There are in that booklet from the New England journal a listing of several hundred diseases. I would say about 60 of them are amenable to prenatal disease. Each one is rarer, but once a family is identified because they had a child they will come back for genetic counseling and frequently for prenatal diagnosis, but not always.

Q. So that you know of one particular instance of your own knowledge?

A. Yes, in which the testing for the particular genetic disease took so long it was after 20 weeks when the fetus was aborted.

(p. 100)

Q. Was this particular abortion carried out?
A. Yes.
Q. In a hospital, I assume.
A. Yes.
Q. In the Philadelphia area?
A. Yes.

Q. Do you know of any other instances where there was an abortion desired and not able to be carried out?

A. I can't speak about other people's experiences confidentially. I don't know.

Q. You don't know?

A. No.

BY JUDGE ADAMS:

Q. Do I take by that answer that what you have been telling us is based on your own personal observations, there may have been a prior incidence of abortions after 20-week periods which are beyond your personal knowledge?

A. That is correct.

Q. But they may exist?

A. They may exist, and I am sure all over the United States they do because genetic counsel service is available in every state.

BY MR. MANSMANN:

Q. But you do not know that of your own knowledge? It is based on your reading or whatever?

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A. It is based on my conversations with other geneticists all over the world, yes.

Q. This one instance that you are talking about, do you know the approximate gestation age of the fetus at the time of the abortion?

A. I believe it to be about 22 weeks.

Q. About 22 weeks was the gestation?

A. Yes.

Q. This abortion was completed and performed even though there had been a policy in the hospital against that?

A. I don't know what the particular hospital's policy was.

Q. That was because of the hospital's policy? We have been talking about 20 weeks as being the hospital's policy.

A. Oh, no. The statement was made that Jefferson's policy was 20 weeks. I know most hospitals and most physicians prefer that. Nobody likes to do a late abortion.

In this case having started the study there was really no alternative but to carry it through.

Q. Of course, you are aware that the procedure that you are describing, the amniocentesis is a fairly new procedure; is that right, as far as diagnostic purposes?

A. It has been used to diagnose Rh papers for quite a while; but that does not involve abortion unless it is a spontaneous abortion. But for genetic diagnosis I would say about five or six years.

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Q. You know from your studies that there are reported cases where the diagnosis was improper; is that right?

A. I know of three cases in which the results did not confirm the amniocentesis. These go back about four, five years.

Q. Nothing more recent than that?

A. No, I do not know of any areas of diagnosis in recent years. Every child that is aborted and every child

that is carried to term after amniocentesis begins the tests are carried out on the living child at the end of the gestation period.

Q. Is this out of the experimental stage, the diagnosis?

A. Yes. There are sources of errors inherent in the particular system.

If one had twins and didn't know it and you did a tap you would only get one twin.

Q. Or perhaps the fluid may have not been from the—

A. One always worries when it is a female child that one might have gotten somehow maternal cells.

Q. You are able to spot that error?

A. I would hope so. We have never had that experience, and I don't know of anyone that really has.

The errors have not always been made in favor of abortion. In one case it was a child that was allowed to come to term who did have a very serious disease. So errors

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go both ways.

Q. I would assume so, that they had made the diagnosis that were was no genetic effect.

A. That is correct.

Q. And the child was carried to term and did have a genetic defect?

A. But the particular procedure that was used is no longer used. A much more refined one for that one is currently used.

Q. It is your testimony that this is accurate now?

A. For every genetic disease that I know for which it is being used it is accurate.

Q. There are other genetic diseases which you have not mentioned which are in that exhibit, you don't have the problem—or do you have the problem with the late diagnostic—

A. Any prenatal diagnosis is going to be in that same time bind.

Q. So that you are talking about not only Tay-Sachs?

A. I am talking about every disease. Anything which requires a cell culture you have that time lag. Any test that you can do on the embryonic fluid then there is no time lag.

Q. So that it has to be after the 16th week?

A. Or generally, yes.

Q. Generally?

A. Yes.

Q. This would be true of any genetic condition in addition

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to Tay-Sachs?

A. Yes.

Q. But you would have a quicker decision in non-cell growing type of diagnosis?

A. It happens to be the one you picked on, which would be open spinabifida.

As common as prenatal diagnosis may be now I am sure that in the next five years many many more of those diseases will prove amenable to prenatal diagnosis, some are common in the Caucasian population. Cystic fibrosis is not now diagnosable.

Q. There is some progress made in these other genetic defects of children born with genetic defects?

A. Obviously if the child is salvageable and nobody is going to be concerned about not allowing that child to come to term.

Q. If a child is salvageable there is no problem, in your opinion anyway, about allowing the child to come to term?

A. This again is a family decision. It is not my decision to impose on the family.

MR. MANSMANN: I have no further questions.

BY MS. LEADBETTER:

Q. This is the booklet that you brought with you?

A. Yes.

Q. Mark it as Plaintiff's Exhibit 7.

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(Exhibit P-7 marked for identification.)

Q. (Continuing) Drawing your attention to Page 3, this indicates, does it not, that Nadler and Gerbey had no maternal or prenatal complications in the series of 150 pregnancies, amniocentesis having been done at 13 to 18 weeks gestation for diagnostic reasons; is that correct?

A. Yes.

Q. So some doctors who are working in this field are doing amniocentesis as early as 13 weeks?

A. This paper is based on some early studies. The general recommendation now is to do it at 16 weeks. Most taps done at 13 weeks do not yield enough cells to grow, and has to be repeated. This is a 1970 paper. That is correct.

Q. It could be tried as early as 13 weeks?

A. Yes, but to no avail and has to be repeated, which is an added trauma for the pregnant mother.

MS. LEADBETTER: No other questions.

JUDGE ADAMS: Does anyone have any other questions of this witness?

MR. MANSMANN: Your Honor, I would change my motion to strike and perhaps we can do this before the witness leaves in case there are any other questions.

MS. WALLIS: May I speak to that motion?

JUDGE ADAMS: We are going to deny the motion to strike at this time. It is always within the ability of the

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Court to strike the testimony as it reviews the findings of fact and conclusions of law. But as of this moment it will not strike with prejudice.

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TESTIMONY OF THOMAS WILLIAM HILGERS, M.D., TAKEN JANUARY 15, 1975

* * * *

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BY MR. MANSMANN:

Q. Now, could you tell me, Doctor, what the immediate complications are generally of a suction and/or D&C abortion? The immediate ones.

A. There are primarily three complications that are significant: The first one being infection; the second one being hemorrhage; and the third one being perforation of the uterus.

Q. O.K. Now, why is there danger from this type of abortion procedure?

A. Well, the abortion process is done or the technique of abortion is done in an area which, from a medical standpoint, is not a clean area.

Q. Now, when you are talking about it not in a clean area, are you talking about the physical facility or the part of the body?

A. No, that's what I mean to clarify. The facilities are clean and sterile in terms of bacteria and organisms that can cause infection, but there is no technical way, even with the use of various kinds of chemicals, to destroy bacteria. There is no way that we can make the vagina or the cervix in that area sterile. It is just a technical

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impossibility.

So that any operative procedure done in this area is liable to infection. The fact that it is a pregnant uterus that we are dealing with does add to the fact that infection is a likelihood. The pregnant uterus is very rich in its vascular supply. It is a sort of, what we would call, a good culture medium. It has all the component's necessary for the growth of bacteria.

Q. And so this is the reason why infection could be prevalent in this particular type of procedure?

A. That's the underlying reasons, yes, and infection occurs from between 5 and 10 percent of women who have abortions.

Q. Now, you are saying that 5 to 10 percent of women who undergo a suction or D&C abortion would stand the chance of having an infection; is that right?

A. That's right.

* * * *

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Q. And the next complication that you had mentioned is the hemorrhaging.

Could you explain to me and to the Court the reason that a complication as a result of an abortion could result in a complication in the nature of hemorrhaging?

A. Well, again we are dealing with an organ which has a very rich blood supply to it. Much more so than the non-pregnant uterus. The pregnant uterus, because of its contents, necessitates a very rich blood supply so that in its termina-

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tion, its evacuation, there are blood vessels which are literally torn through in the midst of the operation, and there is a certain percentage of women where this bleeding is not easily controlled and the bleeding will be of significance, more so than there would be anticipated expected bleeding at the time of the operation, but in some woman it is anticipated bleeding, and much more than anticipated. It would then become significant.

Q. O.K. When it becomes significant, is that called a major hemorrhage?

A. Yes, that's one way of referring to it.

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Q. And you have also talked about perforation and you are talking about perforation of the uterus, I assume?

A. That's right.

Q. And I believe the Court has an understanding as to the method that is utilized in this procedure, and is it the introduction of the instrument that causes or presents the potential risk of perforation of the uterus?

A. That's right. It is not in the process of dilating the cervix or the mouth of the womb in which this occurs, but it is in the curettage aspect or the scraping of the womb by and large that this occurs either with the suction apparatus or the scraping curettage, the two types, and the perforating of the uterus occurs because this is essentially a blind procedure, and the physician is not doing the procedure under direct vision. He can't see, for instance, the top of the uterus or the womb when he is doing the operation, and at times the instrument will perforate through and enter the abdominal cavity.

Q. And what is the consequence of this type of perforation?

A. Well, it depends on where the perforation occurred and to what kind of damage resulted. There are certainly a large number of women who can have perforated uteruses and nothing happens to them. They are only observed for 2½ hours and the perforation heals without any consequences, but more and more we are seeing reports in the medical literature,

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particularly now in the United States, where the blood supply, for instance, to the uterus, the major arterial blood supply to the uterine artery is perforated and lacerated, resulting, of course, in major internal hemorrhage or where the bowel is perforated as well.

During the process of this perforation of the uterus, it can result in infection and overwhelming abscesses, peritonitis, and so forth.

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Q. And, Doctor, are they the immediate and perhaps because there is the three-week intermedial complication, that could reasonably be anticipated from an abortion procedure?

A. Yes, I think so.

I might throw out one other that is perhaps more of an—in terms of a minor problem, and that deals with

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retained placental products or product of conception, some people like to refer to them. This is tissue that is left in the uterus following the abortion. By and large this is not much of a problem with the D&C type of abortion because the woman is scraped clean, but it is a little bit more of a problem with the suction type of abortions.

Q. What is the effect on the woman if there is part of the placenta remaining?

A. Well, it does a couple of things. First of all, that tissue left behind is a good culture medium, as I referred to before, in the sense that it can introduce bacteria and be a stimulus for infection or site for infection, and the other problem is that it doesn't allow the muscle of the uterus to work effectively and so hemorrhage is more common when this happens, but as a result of this, people doing these procedures, by and large, follow up this suction procedure with a sharp curettage of the womb to prevent these problems.

Q. And that would generally prevent the problem if there is a curettage after the suction is applied?

A. That's right, it prevents the problem of having placental or tissue left behind. It doesn't prevent the other problems that I have referred to.

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Q. Doctor, we also had described to us yesterday the saline

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and prostaglandin methods of abortion.

Can you tell the Court, briefly, what the medical complications are from a saline-infused abortion?

A. The same kind of complications medically are found in saline abortions as any other abortion, mainly infection and hemorrhaging, primarily.

With a saline abortion, because it is more "normal," it requires going through a labor process of several hours, there is a fairly high incidence in which there is retained placenta material and retained tissue.

Q. How is that removed, the placenta, after abortion?

A. It requires a curettage, or scraping of the womb to remove the tissue.

Q. That requires the undergoing of a D & C?

A. Yes—not the "D," which is the dilation, that process occurred; but only the scraping of the womb.

Q. These complications, would they appear with the same frequency, other than the retained placenta? Would they occur with the frequency which you previously described with the induced abortion by C section and D & C?

A. They would be a little more common than they would be for the first-trimester abortion.

Q. Would it be statistically higher?

A. From a clinical standpoint a little bit higher.

Q. The retained placenta, do you know how often that would

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occur in a saline infusion?

A. 20 or 30 percent would be a ballpark figure. with the use of saline or salt.

Q. Are they complications that the physician would expect in a saline-infusion abortion?

A. These would be anticipated. There is one I didn't refer to that I should mention.

When a woman has a salt solution that goes into her uterus, there is reaction that goes often into her system. This occurs in a woman that has a saline-immuno infusion. This one is a reaction that affects the blood's ability to clot.

In many women that would be a minor situation, either to her or her physician. By chemical tests, we can tell this is what happens.

In rare occasions the disruption in her blood-clotting mechanism is so severe that she will have a major bleeding, much in the same way as a hemophiliac would have.

Q. Would this be in a small percentage of women, Doctor?

A. The problems of the blood occur in almost all women; but in any major degree, it's a small percentage of women. It's small enough that we couldn't put a percentage figure on it.

However, this is a significant figure because of the material deaths that have occurred.

Q. This would be reflected in mortality rates for saline

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abortion?

A. This is significantly higher for first-trimester abortion.

Q. Do the same complications that you previously described as long-term, or latent complications—would the physician expect to find them in a saline-infused abortion?

A. Such problems as miscarriage and other kinds of pathological problems, are not generally associated with the salt-immuno procedure.

Q. As far as the long-term complications that you just listed, you would not find that complication as a result of a saline abortion?

A. Yes. With the exclusion of trans-placenta, those are the same as the other abortions which problems are unique with the first-trimester abortion, the D & C and D & E. Many of them are associated with the problems of widening, opening the mouth of the womb.

Q. Is that the reason they would not be anticipated, because of a saline abortion?

A. That's right.

Q. In the saline abortion, there is a more natural process involved in that abortion?

A. Natural from this standpoint: it involves the woman going through labor. It is unnatural from a lot of other standpoints. The contractions that occur in labor pains are much stronger, if you measure them with certain instruments

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we use for that.

You get a tear in the mouth of the womb following a salting-out procedure, a complication I will not refer to, but there have been a number of cases on that.

Q. Would that result in scarring, Doctor?

A. It may, but not necessarily in the same problems.

Q. Doctor, in the prostaglandin abortion, would the morbidity rates be about the same as the abortion infused by saline?

A. I think from my own investigation, the morbidity rates are about the same. We still don't have enough information with regard to prostaglandin abortion to know it is higher, lower or about the same. The indications are that they are comparable.

Research in prostaglandin as to their use has only been going on for about four years. It will take more time to throw out a line on it.

Q. Would the prostaglandin procedure—would that be safer from a mortality point of view than the saline?

A. I can't imagine it would be safer. But, frankly, we don't have good, solid information yet because it is quite new.

I can't imagine it would be safer than the salting-out procedure.

Q. Now, Doctor, there is one method left, the hysterotomy method.

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It has previously been described as a miniature C-section. Is that accurate?

A. From a surgical standpoint, that is reasonably accurate.

Q. What complications arise from a hysterotomy?

A. The hysterotomy abortion carries with it the highest mortality rate for all procedures of abortion.

In New York there was 350 per 100,000, and that has been reduced to 200 per 100,000.

In the hysterotomy you run into the same problems as any major abdominal operation. The overall incidence of complication runs 35-45 percent, which includes infection and hemorrhage, primarily. There are other nuances, but they are the primary ones involved.

Q. Do you know what the percentage the physician could expect as far as hemorrhage and infection in hysterotomy?

A. 35 to 40 percent.

Q. Would the performance of a hysterotomy normally require having subsequent children by C-section?

A. As a general rule a subsequent child would have to be delivered by C-section. As a general rule that would be accepted medical practice.

Q. What is your medical opinion where all of these procedures should be performed?

A. I think they should be performed in the hospital setting with the proper kind of back-up, blood teams and other kinds

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of specialities; a cardio-pulmonary resuscitation team would be available, and the whole gamut of expert care.

* * * *

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Q. Doctor, you testified that one of the leading causes of motor and mental retardation was premature birth to the extent it occurred.

A. That's right.

Q. Can you tell me whether or not the possibility of such mental and motor retardation would be apt to apply to a fetus born and maintained in life, delivered, say, between 20 and 30 weeks. Would there be a risk of this problem?

A. There is a risk of this problem with any infant born prematurely.

Q. Can you relate the risk which would occur or which would be endured by a fetus of less than 1000 grams, say, to a fetus of around 2500 grams or slightly less?

A. Oh, the smaller the infant, of course, or the more premature the infant, the greater the chance that this is going to occur. In fact, that's where the modern thrust or the thrust of modern obstetrics really is, in the prevention of premature birth, as much as we possibly can.

Q. Let me ask you this. If we had an infant delivered at, say, 600 grams, and we were able to maintain life, can you give the Court an estimate of the possibility of mental

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or motor retardation of significant symptoms?

A. Well, it depends on what you mean by "significant."

Q. I will withdraw that. You define it however you like, Doctor.

A. Well, that is still a good question because I am not sure that I can give you a good standard medical definition of what the significance is from a motor retardation or a mental retardation standpoint.

I can tell you that for an infant delivered below 1000 grams, and I must qualify this to a certain extent because

I am recalling on my memory, but, as I recall, the incidence of mental and motor retardation runs in the range of about 15 to 17 percent.

Now, I must say that there are—

Q. I am sorry, I didn't hear the percentage.

A. 15 to 17 percent.

Q. Thank you.

A. But I must quickly add to that that there are recent publications now coming where these high risk infants are receiving a particular kind of intensive care and they have been followed up now to the degree where these kinds of problems are being either prevented completely or being markedly decreased in terms of their intensity.

Q. You would hope to reduce the risk as time goes on, I assume?

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A. Well, there are two ways of approaching the problem: One, to treat infants, and this is where we have a great deal to go in terms of our medical knowledge.

The other is to keep the infant in its best location, which is in the mother's womb, and I think that is where the general trend of American obstetrics is headed in terms of the world situation, is to try to avoid premature birth if at all possible.

It is very difficult to take a simulator or artifically produce the conditions which are beneficial to the child while in the womb.

Q. In order to understand the context in which you were working with that statistic, the 15 to 17 percent, I just want to ask you a couple of clarifying questions; one of which are we talking about a premature infant of 1000

grams or slightly less handled in a specialized or intensive care situation?

A. Not necessarily, no. We are talking about the general handling of these infants.

Q. In an ordinary as opposed to a non-teaching hospital?

A. That's right.

Q. Then you feel that with neonatology and with specialized equipment, we might be able to improve birth rate?

A. I think that we will be able to improve that, but we will never be able to overcome it, I am sure.

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Q. Secondly, as a matter of context, does the 15 to 17 percent relate to all births at this age or to those surviving for some period of time, and, if so, what period of time?

A. It refers to those who survive and obviously the ones who die, it is not a question of mental or motor retardation.

Q. Yes, you are excluding them from the population?

A. Sure.

Q. And what, if you will, lengths of survival is necessary to determine the probability or the incidence of this mental or motor retardation?

A. Well, that is a difficult question for me to answer since I am not directly involved with either the study or the care of these infants. That is not my field of expertise.

Q. O.K.

Doctor, I want to ask you to give us, if you will, your opinion in gestational age of viability, and I will define the term for you, if I may.

I would like to define for you or for you to use this definition: Viability means capability of a fetus to live outside the mother's womb albeit with artificial aid, and you may assume that the artificial aid is not the intensive aid available only in a teaching hospital for the purpose of the definition I am giving you.

Could you tell us at what gestational age in your opinion, that status; that is, viability, is attained?

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A. Well, first of all, in my opinion, one cannot give a specific gestational age. The concept of viability as you have defined it depends on a number of factors.

Q. You may wish to indicate to the Court, incidentally, your reservation about the usefulness of the definition at all in terms of your own philosophy.

A. Well, I can only say that from a practical medical standpoint the term viability as referred in general to the kind of definition that you have given, the ability for the child to live independent of the mother, but the determination of when a child is or is not viable is one that can never be accurately determined before the child's birth. Some reasonable judgment can be made regarding it.

One has to put together though a number of factors. One has to put together the history, the medical history of the woman; when her last menstrual period is. One has to consider the size of the infant. Most medically accepted concepts talk about 500 grams.

As a matter of fact, there have been recorded incidents of children living on to adulthood at smaller than 500 grams; as low as 370 or 380 grams so that the size, weightwise, of the baby would be quite an important consideration.

Gestational age does fit into sort of the multi-factor approach one has to come to deciding whether

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a child is viable or not, and I think the consideration of what facilities are available in a community also enters in. Certainly the medical center, where there is well qualified or very specialized, if you will, medical care, the concept of viable will have a little bit different meaning than it will have if you are out in a rural area where we have no such facilities, and certainly one thing we do know is that viability is being pushed back and back.

Q. Let me ask you another question along that line. I realize that it makes it difficult to answer, and I will allow you to define the terms any way you like, if you wish, but I again want to use the definition of my ability I gave you; that is, the ability of the fetus to live outside the womb albeit with artificial aid.

I want to ask you, Doctor, if you would give us the factors or the gestational age which would allow you to determine, or at which point you could make a determination that a fetus is viable or that there is sufficient reason to believe that the fetus may be viable exercising your professional skill and care. Can you give us a gestational age or some other factor which would relate to that to permit you to make the determination?

A. Well, I think what I just completed saying was that for me to make any reasonable judgment regarding

viability, and it would not in any way be infallible judgment, for me to make

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any sort of reasonable judgment regarding it, I would have to consider a number of variables.

One is the gestational age. One would be the size of the infant as I would estimate, or guesstimate as we would say in obstetrics, because it is very difficult by abdominal aid, feeling the mother's womb, abdomen, that would require investigating her past medical history; when her last menstrual period was; whether or not that fits in with the size of her uterus, and certainly in terms of whatever medical facility might be around in the area at the time, and whatever kind of medical advances we might be working on at the present time also.

Q. Can you give us, if you will, assuming the medical facility available in a normal hospital, but not a teaching hospital, those indications in terms of weight which you are able to palpate or X-ray and gestational age as you term it from the history given you by the woman, at what point you yourself would reach the professional judgment that the fetus may be viable?

A. I think that if one has a reasonable judgment medically that the woman is four and a half to five months pregnant, both from terms of the size of her uterus, and in terms of her past menstrual history, and if the child's estimated size were over 400 grams, by estimation one could make a reasonable judgment that this baby has now reached that point

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of what we call viability, but I must say that—

Q. That is a might be viable proposition, right?

A. That's right.

Q. Go ahead. You were going to say, "I must say."

A. Well, I must say that the determination of a 400-gram size unborn infant is very difficult.

Q. All right.

Now, Doctor, if you were to attempt, given the determination, the factors as you have outlined; e.g., an infant of something on the order of 400 grams, and I think you said five and a half months pregnancy; that you desired to give that infant the best chance of survival although you were going to remove it from the womb, what procedure would you use?

A. If I were to give that infant the best chance of survival given—

Q. The factors you enumerated. How many months was it?

A. Given removal from the womb?

Q. Yes.

How many months did you indicate?

A. Four and a half to five months.

Q. Four and a half to five months, at 400 grams, approximately slightly more.

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BY MR. MORRIS:

Q. Doctor, you have now read Section 5-A of what is referred to as the Abortion Control Act in Pennsylvania, and what I want to ask you is under that section if you were to exercise that professional skill, care, and diligence which would preserve the life and the health of the fetus, as well as the life and the health of the mother,

as indicated in that section, with all the other qualifications of that section, what procedure would be used to deliver a four and a half to five month fetus which weighed 400 grams or so?

A. I would think that the use of prostaglandins would probably be the best procedure to use.

Q. And what would be the chances of survival of that fetus if you used that treatment?

A. Well, it depends on another variable. Viability depends not only on some of the factors that I have explained but it also depends on racial differences.

As a matter of fact, black infants have a viability that is much earlier than white infants, for example.

Q. I am asking you to assume then, if you will, a black infant. What would the chances of survival approximately be for that infant?

A. O.K. If the infant is at approximately 20 weeks gestation,

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survival through the neonatal period would be in the range of 20 to 21 percent to make it through the first month of life, and this is based on a study done in New York City of 650,000 live births broken down by gestation age and by weight.

Q. And I take it some 15 to 17 percent of those might have motor retardation or some form of mental problem?

A. I am not advocating that this be done, sir, so I—you know, I hope that that can be understood. I could not be doing this for a number of reasons, one of which—

Q. Why would you not be doing it?

A. Well, one of them, the exact thing that you are talking about, the problems that one has in terms of prematurity, and my role as an obstetrician is to take care as best I possibly can of two individual patients.

If I am going to risk the premature birth of a child, I am doing a great disservice to that child, and I would not perform this procedure as a result of that. I can prevent that problem, that 15 to 17 percent, easily.

Q. The best way, I take it, in terms of your advice, is unless it is an otherwise normal pregnancy, to preserve the life of the child would be to carry it to term?

A. Oh, yes.

Q. Doctor, I notice you selected prostaglandins for this procedure under 5-A rather than hysterotomy, or perhaps it

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would be called a Caesarean section if it would be a live birth. Why?

A. Well, the prostaglandins, I think, are probably safer than a hysterotomy, and as I indicated before, we don't have all clear information yet on prostaglandins, but from what we do have, I would think that they would be quite a bit safer than a hysterotomy.

* * * *

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Q. Doctor, our last question related to the 15-to-17 percent which you related when you were discussing motor retardation.

I ask you if you can, using Exhibit 6, clarify that statistic which you gave us?

(Handing P-6 to the witness.)

A. The incidence of mental retardation is 3.5 percent for infants weighing 1500 to 2500 grams; the premature group is 7.4 percent; infants weighing less than 1500 grams, the incidence is 17.7 percent.

That indicates what I was saying, the smaller the child the higher the incidence.

Q. Lastly, as you have used the material for providing the statistic, what in terms of severity do you classify as mental or motor retardation?

A. The data as I just presented it is not broken down in terms of degrees of severity.

We are talking about children who will become cerebral palsies, some children will have gross motor retardation and mental retardation.

As to severity I don't have that broken down and I don't recall from my source of information what that breakdown would be.

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TRIAL TESTIMONY TAKEN JANUARY 16, 1975

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MRS. MANSMANN: From the deposition of Dr. Gerstley. Since I am not certain we have previously identified it, it was taken November 21, 1974. Present for Dr. Gerstley is Miss Sharon Wallis; for the Commonwealth Mr. Mansmann.

At Page 13:

"Q. Is prostaglandin a fairly new method?

"A. Yes.

"Q. Have you any experiences with that?

"A. Have I used it myself?

"Q. Yes.
"A. No.
"Q. Your hospital?
"A. Yes.
"Q. Do you have any reports back on the success or lack of success?
"A. It is by and large a quite successful method. It is not quite as successful as the saline method in terms of the fact that with a saline usually a single injection will produce the abortion in time, whereas

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prostaglandin you may have to go to repeated injections for it to be successful. Granted those two things, I think one method is just about as successful as the other."

MRS. MANSMANN: Back to the deposition of Dr. Franklin at Page 33:

"Q. What about prostaglandins, have you had any experience with it?
"A. No experience with it.
"Q. Do you have any knowledge of it?
"A. I have done some reading.
"Q. Do they carry the same life threatening—
"A. No. A small volume of prostaglandin can be induced into the uterus. It goes into the cervix. You can put a tube into the cervix and put the prostaglandins in, constrictions ensue and the patient aborts.
"Q. What effect does that have on the fetus?
"A. I don't know. I have no idea as to whether it has any effect on the fetus or not.

"Q. Do you know whether or not the saline does?
"A. Yes, I do. Saline does the fetus in. It kills the fetus."

* * * *

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"Q. Do you agree there is one aspect present in the abortion procedure that is not present in the other reproductive surgical procedures and that is the potential life that would be there.
"A. Yes, I agree with that."

MR. MORRIS:

"Q. And do you agree that at some point—and this is probably your own philosophical reasoning—at some point there is an interest in the preservation of that fetus?
"A. Not necessarily. I have thought a lot about this question and I believe that life is extended to a fetus or a baby capable of living, if the baby is neglected

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in some way, that does not live, so that one of the prerequisites for life is that someone wants you to live. It may be that they want you to live enough to start an i.v. or to put you on a breathing machine or ventilator but it simply may be that you can be brought into a household where you are fed and sheltered and clothed but the message is you are not wanted, and I believe there is good documentation of absence of growth in children for emotional reasons, namely, societal rejection, and there is a famous paper from the 30's of a nursery where babies were attempted to be raised in total asepsis, no bacteria at all, and these babies died because they were not handled, not talked to, in fact, neglected. So my own philo-

sophical definition of life necessitates other human beings who want you to live. That is why I regard this thing, again, as a piety. It is not practical. If the State legislature wanted to do something, they should provide stipends to single mothers, they would provide day care centers, they would provide rewards for having babies. What they are providing is punishment for having them or punishment for having the abortion, excuse me. Welfare mothers would not qualify in this case. She would have to find the money in this case."

MRS. MANSMANN: Again reading from Dr. Franklin's deposition at page 18. The discussion was with a saline infusion. The question is:

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"Q. Is this done as an inpatient procedure all the time?

"A. Not constantly. There are some areas where physicians have reported doing it as an outpatient procedure.

"Q. What would your medical opinion be on the advisability of that?

"A. Not taking a great deal of risk to do it as an outpatient procedure. From the psychological, I would view the procedure as far more difficult than the suction abortion and, therefore, require more support of the patient.

"Q. Using one of those procedures, it would be of more psychological harm?

"A. The woman is having 8, 10 hours of contractions similar to labor, and to send her home to an environment you know nothing about seems to me inhumane.

"Q. And is the fetus expelled?

"A. The fetus is expelled and the placenta is usually expelled. Sometimes you have to help that out. Sometimes it is incompletely expelled.

"Q. That is incomplete?

"A. Yes.

"Q. Does that require some surgical—

"A. Yes, to get the remaining placenta out.

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"Q. Is the fetus expelled in what form, that the woman could see the fetus?

"A. Oh, yes. Fetus is expelled either covered by the sac or simply as fetus with the cord attached."

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TESTIMONY OF WILLIAM J. KEENAN, M.D.,
TAKEN JANUARY 17, 1975

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* * * *

BY MR. MANSMANN:

Q. Will you tell the Court, please, Doctor, what the relationship is between the mother and baby while the baby is in-utero?

A. Well, the baby is obviously depending on the mother and father for conception and well-being.

While the baby is in-utero it depends on the mother for oxygenation and nutrition across the placenta; and is dependent upon the mother for temperature control and being warm.

Q. So that the baby would depend on the mother for warmth, nutrition and the supply of oxygen; is that correct?

A. That's right.

Q. Are there any functions for which the baby depends solely on the mother?

A. Well, in the last 20 years there has been considerable research in this area. More people are beginning to touch on the area of the metabolism of the fetuses and nutrition of the babies.

In terms of independent function, most of the things—as an example, thyroid hormones, which is

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necessary for growth—we are all familiar with people that have a malfunctioning thyroid gland—the baby depends on itself for that.

In terms of the baby's insulin, insulin is secreted by the pancreas, which is obviously an independent function of the baby.

The baby's independent functioning is measured by 12 weeks' gestation, so that the baby has evidence that his own functioning is doing the job. Most of that is done in Pittsburgh, by the way.

Q. Thank you. Doctor, can you give us any other examples for which the baby is responsible for himself or herself, and not dependent on the mother?

A. There's a lot of them. For instance, the baby is on circulation, and all the physiologic functions we have obviously are developments and the baby—by eight weeks the heartbeat forms, and we have been able to use advanced technology to detect the baby's heartbeat and circulation in 12 weeks.

Q. Now, during the course of this trial we have heard the process called amniocentesis. Can you tell us what that is, Doctor?

A. Well, that is using a needle to puncture the woman's abdominal wall, which goes through the wall of the uterus and into the amniotic sac, and a sample of that fluid is

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drawn for analysis.

Q. So that the fluid withdrawn is the fluid of the baby?

A. The bulk of the fetal urine is the baby's as well as the amniotic fluid, and the baby excretes it through his kidney.

Q. At what period of gestation is this procedure normally done?

A. We do quite a few amniocentesis. I work in a city.

It depends on the indication. We normally start that at about 20 weeks' gestation. We check throughout the pregnancy.

Q. When would the earliest period of gestation be in which amniocentesis would be generally carried out on the mother?

A. In our hospital, Cincinnati General Hospital, the routine is to do it at 14 weeks.

Q. Would this be the time at which this procedure would be completed for the purpose of detecting a possible Tay-Sachs problem in the child?

A. This is a routine where if the family is suspected of Tay-Sachs disease, the system as it works in our hospital is to schedule amniocentesis for 14 weeks.

Q. Doctor, is there, while the baby is in-utero, a period in which there is a gas exchanged within the fetus?

A. The baby is constantly—there are two organs in the fetus designed for gas exchange; one is the placenta and the

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other is the lungs.

The baby does not use the lungs for respiration in-utero. Beginning at 12 weeks there are various vigorous respiratory movements of the fetus.

The baby circulates blood through the placenta, which is his organ, and it also picks up nutrients.

Q. The exchange is done through the placenta originally; is that correct?

A. Yes.

Q. Is it done through the placenta the whole time that the baby is in utero?

A. Yes.

Q. At that time there is also the development of the lungs?

A. Yes.

Q. Can you tell the Court when the first marked development occurs in the fetus?

A. There are several times that we use to teach medical students. To illustrate, the development is a continuing process.

One of those landmarks is 8 weeks' gestation when the organ development is complete. At that time the baby has all the organs that he ever will have. He has a liver, spine, et cetera.

The organ genesis is complete at 8 weeks.

Q. When is the heartbeat first able to be detected, Doctor?

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A. The heartbeat is formed by 8 weeks, and is probably beating at that time.

In terms of documentation, it is 12 weeks by using ultrasonic techniques which are readily detectable.

Q. In other words, the heartbeat is able to be detected between 10 and 12 weeks of gestation?

A. Yes.

Q. What about the development of the fetus when it reaches 20 weeks' gestation?

A. That would be a premature infant. The skin is thin at that point. A black baby is a black baby; a white baby is a white baby.

The babies in my experience, in terms of the lung development at that time, for a period of the time the baby is able to exchange gas at that time, and there is vigorous respiratory movements in terms of picking up oxygen and getting rid of carbon monoxide.

Some of those babies develop infection and other things and others go home.

One had to change our opinion a little bit as to preconceived notions. We talk about a baby that we see at 20 weeks' gestation, and there is respiration and ventilation at that point.

Q. You are talking about exchanges of gas in the lungs as opposed to through the placenta?

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A. Yes.

Q. Do these 20-week babies survive?

A. Not in our experience, no.

Q. What is the development of the fetus at 26 weeks?

A. At 26 weeks, if you continue along the same line looking at ventilation, the baby does have vigorous respiratory movement, does exchange gas and many of these babies survive to go home.

There may be some sort of change in the baby's pulmonary functions at that time.

Q. As the fetus matured from 20 to 26 weeks, that gives the baby a better chance of survival; is that correct?

A. Yes.

Q. There is an increased ability to exchange gases without dependence on the placenta?

A. Yes. The study of pediatrics is growth and development.

Q. Is there a high mortality rate in the 26-week fetuses?

A. There are. As the gestation plods along the line, there is an increasing mortality as the baby increases in development.

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Q. Could you tell us about a baby who is between 26 and 28 weeks of gestation, what would his chance of survival be?

A. In the nursery that I am, you know, primarily responsible for, which is the Cincinnati General Hospital, which is a hospital by charter in Cincinnati that takes care of the indigent patient, our experience over 1973-1974 with 65 babies in that range that you are talking about.

Q. Between 26 and 28?

A. Yes, is 50%.

Q. What about the rate of survival in a 28 to 30-week baby?

A. Well, it goes up dramatically. In our experience, 60% survival.

In a recent article in a journal called "Pediatrics" in December of 1974, they had a 75% survival in that weight group category.

Q. And in your experience about 60% and you know of studies that indicate a 75% chance of survival in a 28 to 30-week baby?

A. Yes.

Q. Doctor, I am going to read to you from the Pennsylvania Abortion Control Act a definition, and I am quoting, "Viable means the capability of a fetus to live outside the mother's womb albeit with artificial aid."

Could you tell us if you would be familiar with that definition?

A. Yes, I am.

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Q. And is it a standard recognized medical definition of that term, viability?

A. Yes, it is.

Q. In the course of your practice have you had occasion to determine whether or not a fetus is viable?

A. Yes, I have, frequently.

Q. How frequently is "frequently"?

A. Well, probably not daily, but certainly weekly.

Q. And would you describe to the Court the method that you would utilize in determining whether or not a particular fetus is viable?

A. Well, on the basis of practice and what everybody does in their approach is first you obtain a history from the mother, just like we would all have histories obtained if we went into the hospital, and with particular

attention directed towards her menstrual history, menstrual dates, trying to determine what time conception took place by using her menstrual history.

Then in addition to that, every woman would be examined externally, by hand, to try to determine not only to look at the height, how much the uterus has grown in total, but also to try to feel for the baby's—the size of the baby's head and the size of the fetal small parts, or hands or feet.

Q. And this is done by an external examination?

A. Yes.

Q. What is the importance of the menstrual history?

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A. Well, the menstrual cycle either—well, menstruation either ceases or markedly changes after conception and so we can take the change or the cessation of menses to indicate what time conception took place.

Q. And the reason for the examination as to the size of the uterus or the abdomen, what is the purpose—what are you trying to learn from that examination?

A. Well, in general the assumption is that this baby is—the more mature the baby grows, and you are attempting to find out the size of the baby by looking at the size of the uterus and the cavity the baby's in, and to look at the size of the baby, too.

Then you try to put them both together and come up with a reasonable estimate of what gestation is at that point.

Q. When you are doing that, would you rely on your medical judgment?

A. Yes, sir.

Q. Is this routinely done in hospitals?

A. Yes, it is a standard the people use every place. If I went to Green County Hospital, which is a hospital that delivers about 400 babies in Ohio, they do exactly the same thing.

Q. So it would be an ordinary procedure?

A. Yes.

Q. And a readily recognizable procedure in determining whether or not a particular fetus is viable?

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A. Yes.

Q. After you had finished your examination, how do you make your judgment on whether or not the fetus is viable?

A. Well, you put the information together, and using a double standard—not a double standard, that's not a good word.

You are using two standards of measurement of gestation and checking one against the other side. Add the information together and with your previous experience, you've come up with an estimate of gestational age.

Now, there are limitations within that in that if I know that I am not a good examiner, for instance, that I really from my previous experience can't tell whether a baby is one pound or eight pounds, I would put less reliance upon that and often—I know a man that I practice with—an obstetrician relies on a certain nurse to tell him, you know, what size she thinks the baby is because he knows that she is more reliable. She has better hands than he does.

Q. So this is part of the process of your making your reasonable medical judgment; is that right?

A. That's right.

Q. Do you use any external data, too, in forming your opinion as to whether or not this baby is viable?

A. Well, by "external data," the way I would interpret that is to mean in previous experience what babies do and what they don't do at a given gestation so—

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Q. It would be that type of information that you would use?

A. Okay, yes. You know, the obstetricians are up-to-date about what our current experience is with a baby of any given gestation.

Q. Doctor, would you be able to base your decision on gestational age alone?

A. Well, not reasonably. I think that's an unreasonable thing to do, take a single parameter and make a judgment on that. In just about every test we have there are certain fallible points and sources of error so I'd say no.

Q. And the reason for that is what?

A. Well, the mother may not remember her dates or if she remembers them, there may be things that influence those dates. For instance, if she has had cessation of menses but she has also had some emotional problem around that period of time, and they may not be pregnant until later, or sometimes in certain women she may have close to a normal menstrual period once or twice after conception, and so you take in, you know, not only was there menstruation, but you know the character of the menstruation and the character of the mother, the mother's previous menstrual history; if she has had regular

cycles, and you would put more reliability on that than if she has had irregular cycles.

Q. Doctor, would you be able to base your decisions as to whether or not this particular fetus is viable on the baby's

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size or weight as you determined it and approximated from the external examination?

A. No. There are failings of that approach by itself, too, in that one is the failing of the examiner; the fallibility. There is a certain error that you would expect that you are within a half a pound, for instance, in your estimate, or you are within a pound, but, you know, it encompasses one or two weeks or three weeks, maybe.

So there is some error in there and then in terms of the baby's growth, you are estimating size and trying to assess maturity and gestation, and some babies grow faster than normal. Like infants of diabetic mothers, for instance, become abnormally large at a given gestation. So that would temper you; the mother's history of diabetes, and some babies grow slower. A mother with chronic hypertensive disease, which is a common illness in our hospital, the babies may not grow as quickly for a given gestation.

Q. So that you would balance these particular factors?

A. Yes, balance one against the other and then come up with an estimate based on a combination of information and how each piece of information fits in with this individual case.

Q. Okay. Are there some new techniques being experimented with or developed which would aid the physician in determining viability?

A. Yes, there are, and most of these techniques are currently

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pretty much within teaching hospitals and experimentally the error and fallibility and reliability of those techniques are being worked out.

The things that we use are amniocentesis and things to measure, for instance, the number of baby cells within the amniotic fluid, so we take over, say, an ounce, and then count the number of fetus—mature fetal cells within that, and then that increases with gestation.

There are certain things that the baby usually puts out in his urine, which we all have in our urine, which increases in concentration with the size of the baby.

Q. This would be another key for you to use to determine what the maturation and gestation of this particular baby is?

A. Yes, and, you know, another promising technique we are using is sonar or ultrasound where you bounce a sound wave off of the baby and pick it up and then by changing the position of your sonar recorder, you can measure the size, for instance, of the baby's head, and the diameter, and so you're looking at a measure of fetal growth, and that has at least some of the sources of error that we talked about in terms of the baby's growth versus his maturity, but it is a very promising technique, I think.

Q. Would that be able to be utilized alone as the determining factor of viability?

A. No, no, that would be—we would not do—we do ultrasound

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diagnosis, but we wouldn't put reliability on that. That would not be good judgment to put our reliance on that measure, no.

Q. That would be a more accurate way than by hand, I assume?

A. It seems to be. It may prove out that way. We have to get more information really.

Q. And is this the same procedure with the sonography, is that used to measure any other portion of the baby?

A. Yes. Well, I mentioned previously that you can use it to record the movement of the heart, the contraction of the heart, and, you know, it is a very nice tracing. You can use it to measure the baby's—you know, the circumference, diameter of his head, and you can measure his length. You move the probe down the abdomen along the axis of the baby, and you can pick up the length of the baby.

Q. Is that what is known as crown-rump length?

A. Yes, crown and rump, yes.

Q. And that again gives you an aid in determining the maturity or size of the baby; is that right?

A. Yes, right.

Q. Could you use that as the sole factor in determining whether or not a baby is viable?

A. No. Again there are some sources of error in the measurement itself people recognize—people who do ultrasound recognize, and then there are sources of error

just from the growth of the baby. You have an average, but the average has a deviation so

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you wouldn't put all your eggs in one basket again.

Q. So you would use a combination? For example, if you were in a teaching hospital, you would use a combination of all or some of these tests or procedures?

A. That's right.

Q. And if you were in a non-teaching hospital, you would use the physical examination that you have described to us?

A. In a teaching institution we use the history and the size of the baby determined from external examination.

Now, in the problem patient, you know, we suspect the growth, that it may not be normal, and things like that, we would go ahead and use other procedures. We don't use those routinely either and they won't—I doubt if they will come into routine use.

Q. Okay. So that is for the problem child that you are concerned about some growth problem?

A. That's right.

Q. So that even in a teaching hospital you would utilize the procedures that you have indicated to us?

A. That's right.

Q. Doctor, would you be able to or are you able to state with reasonable medical certainty the viability or the same situation will exist in every particular case?

A. No. If the mother has an infection, for instance, that would enter into your judgment whether this baby is viable in a

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mother with an infection, and in a 25-week fetus, I think the chances for that baby are very grim. Whereas, the same baby, say, with a mother who has had good nutrition, she has had good pregnancy history, you have good reliance on your information. All those kinds of things, that a baby would have an even better chance so there are a lot of variables, not with the individual, but in judging the individual case. There are things that you take into your formula for judging that case.

Q. All right, and also, Doctor, are there factors that are inherent in, for example, the sex of the baby?

A. Yes, and I guess not really remarkable, but for a given baby after a given gestation, the sex is really very important to determine in that females survive with a given illness and males have a lesser chance of surviving with a given illness.

So often, say, if I bring a sick baby from the delivery room to the nursery, the nurses look at the baby and see if it's a boy or girl and say, "Oh, well, gee, you know, it's too bad he is not a girl," or something like that, just in terms of survival so, yes, that is important.

For instance, there is another one. Race seems to be important. For a given size the baby who is black has a better chance of survival than a baby who is white. A black female in terms of survival is better off than a white male. Those are the extremes.

Q. Doctor, you have explained to us how you would attempt to

(p. 546)

determine gestational age and could you tell us at what point you would place viability? First of all, let's take 28 weeks.

A. Well, 28 weeks for sure, and we have mentioned those babies with a 50—60%, you know, survival, in a nursery. Now, these are babies who are sick. These are babies who had complications; whose mothers were infected, whose mothers had hypertension, all kinds of other things going on, so this is experienced in the real world. It is not an optimal experience.

We hope by better, for instance, better prenatal care, we will be able to optimize that experience with small babies.

Q. What about 26 weeks?

A. Well, again I indicated that many of those babies survive. By "many," I would judge between 10 and 30%. The mortality is increased, you know, with a 26-week gestation versus 28-week gestation, but there is a maybe chance.

Q. And what about before 26 weeks?

A. Well, I think that's more of a problem and in our experience we have about—you know, it is only possible in any case, you know. Well, not from 26 weeks down, but, say, from 26, 24, or so.

Q. So in that period you would say the baby would not be viable, but maybe viable?

A. Yes, yes.

Q. But from 26 to 28 weeks would it be your opinion, and based on your experience, that the baby would be viable?

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A. Yes.

Q. Doctor, is this—

JUDGE NEWCOMER: That is not what I understood him to say.

JUDGE GREEN: I didn't either.

JUDGE ADAMS: The testimony hasn't been thus far. You gave us percentage figures before.

THE WITNESS: Yes.

JUDGE ADAMS: I have jotted them down. You said from 26 to 28 weeks. Of 65 babies that that you had observed in your hospital, there was a 50% chance of survival.

THE WITNESS: That's right.

JUDGE ADAMS: That seems somewhat inconsistent with the last answer. Maybe I am not—

BY MR. MANSMANN:

Q. Doctor, would you explain to the Court, first of all taking 28 weeks.

JUDGE GREEN: Maybe I misheard the question and answer. Maybe the stenographer could read it back.

THE WITNESS: Maybe I misunderstood the question.

BY MR. MANSMANN:

Q. Maybe if we started over again at 28 weeks. Gestational age 28 weeks.

A. Okay.

Q. Would it be your opinion that the baby would be viable?

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A. Yes.

Q. At 26 weeks would it be your opinion that the baby would be viable?

A. Well, mortality has increased.

JUDGE NEWCOMER: In order that I can understand this, when you say that the baby will be viable, are you suggesting that if it is more than 50%, the baby will be viable? You gave us percentage figures.

BY MR. MANSMANN:

Q. Okay. Doctor, when do you determine, at what percentage point do you determine that, as far as chance of survival is concerned, a baby would be viable?

A. Given the disease rate in this country and in our prenatal society, a 10% survival rate for the very small sick baby is—we would say has the highest survival.

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Q. That is viable?

A. That is viable.

Q. So that from 26 weeks you indicated that there was a 10-to-30 percent chance of survival; is that correct?

A. Yes. So below 28 down to 26, that would be about 10-30 percent.

Q. Based on those percentages, would you say that a 26-week baby would be viable?

A. Yes.

Q. And anything below 26 weeks, would you say that baby would be viable?

A. Not anything below 26—26 to zero.

Q. What about 26 to 20?

A. It may be.

Q. That may be viable?

A. Yes.

Q. You wouldn't say definitely the baby was viable?

A. No.

JUDGE GREEN: Doctor, didn't you use the 26-to-24 weeks before?

THE WITNESS: Yes, sir.

JUDGE GREEN: Are you saying it is the same whether you use 26 or 24 weeks?

THE WITNESS: In our current experience, sir, 26-to-24 week babies come to the nursery and go home from

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the nursery.

JUDGE GREEN: That is the 10-to-30 percent?

THE WITNESS: Yes. Now, if you go down to 26 weeks, we do have babies that come to the nursery and survive for a couple of days. They succumb to infection and pulmonary insufficiency and fail.

We don't have survivors in terms of babies going home. We are very close to that point in terms of our current technology.

JUDGE GREEN: That is, the lowest period in which you have babies going home are 24-to-26 week babies?

THE WITNESS: Yes, sir.

BY MR. MANSMANN:

Q. Now, Doctor, in answer to one of Judge Green's questions, you indicated that technology is expanding or advancing; is that right?

A. Yes.

Q. Could you elaborate what the prospects are?

A. This is very important in discussion with my colleagues in the Cincinnati Perinatal Association and the Society for Pediatric Research. We feel it is urgent that you don't define it so closed.

To define it at 28 weeks, that may have been appropriate five years ago but it's not appropriate today; if you define it at 24 weeks, that may be appropriate today

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but it may not be adequate six months or three years from now.

In all of medicine when you talk about any of the advances of the definition of viability, which may be documented by current experience, it may not be supported by any experience in three months or eight months or 24 months.

It's an expanding concept. There's always flexibility downward in lesser-gestation babies.

JUDGE GREEN: Are you saying that in this area it is only the judgment of the treating physician the only thing that can be relied on?

THE WITNESS: Judgment and experience, yes.

JUDGE GREEN: That is the judgment of the treating physician at that time?

THE WITNESS: Babies, usually, of a thousand grams regularly survive. In a couple of community hospitals in Central Ohio they sent us their small babies, because all of their small babies died before.

Now, they are starting to send their small babies to us and we take care of some of those babies in our own nursery at Cincinnati General Hospital.

I know people in Cleveland, at Western Reserve, where they influence the community hospital's practice. It is not necessarily the individual experience, but sort of a cumulative medical-practice experience.

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JUDGE GREEN: All this knowledge and experience and studies, a doctor who has to make a determination whether or not there may be viability, are you saying that has to be his personal judgment?

THE WITNESS: Yes, sir. In making up the judgment he is familiar with the literature; he knows what goes on in the nursery.

JUDGE NEWCOMER: Are you saying that another physician in reviewing that data would not be able to change that decision or judgment?

THE WITNESS: I think medical judgment assessment is what's available to that physician. I don't think anybody would disagree.

JUDGE NEWCOMER: You do not feel another physician would change that judgment or decision?

THE WITNESS: I don't think so.

JUDGE ADAMS: Let me ask it this way: Supposing the woman is on the table in a teaching hos-

pital and there is a question as to whether the fetus she is carrying is viable, and there are 10 doctors present who have a skill in this field, would there be room for differences among those doctors as to whether the fetus being carried by this woman is or is not viable, and the gestational age of the fetus is somewhere between 20 and 25 weeks?

THE WITNESS: There wouldn't be any substantial

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disagreement.

JUDGE ADAMS: But you could not tell us what the answer would be?

THE WITNESS: I can tell you what the answer would be in our delivery room. The baby would not survive.

JUDGE NEWCOMER: Does survival and viability mean the same thing in that context?

THE WITNESS: In the figures that I have given you this talks about babies coming to the nursery, that were delivered in the room, survival in neonatology period, is the first 28 days after birth, and then they go home. That is accepted in the organization.

JUDGE ADAMS: If we have the same setting that I was hypothesizing a moment ago, and the gestational age is 24 to 26 weeks, and you have this same woman on the operating table, and the physicians and the same data, would there be room for difference of opinion among those physicians?

THE WITNESS: This is getting closer to the number. There would be more discussion and they would come to a reasonable agreement.

Depending upon the current state of practice in our hospital and intensive-care nursery, the judgment would be to deliver the baby. The object would be to safeguard the fetus.

At Green Conty Hospital they probably would

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not do anything special. They would say, "Yes, but we would not be able to insure the survival of that baby."

JUDGE ADAMS: Thank you.

BY MR. MANSMANN:

Q. Doctor, then it's the reasonable medical judgment of that particular physician whether or not the baby would be viable?

A. Yes.

Q. He would take into consideration whether he was in a teaching hospital as opposed to a rural hospital?

A. Right. We have a rural hospital closely linked with us. Their situation would be different than Greene County Hospital.

We have a hospital between hospitals; we have an incubator there, resuscitator and delivery, and they can bring the baby back to our hospital, depending on prior arrangements.

MR. MANSMANN: No further questions.

JUDGE ADAMS: Ms. Leadbetter?

MS. LEADBETTER: No questions, Your Honor.

JUDGE ADAMS: Mr. Morris.

Cross-Examination

BY MR. MORRIS:

Q. Doctor, I wanted to make sure I understood one or two definitions.

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When you say "gestational age," are you talking about gestational age measured from the last menstrual period or conception?

A. Upon a reasonable estimate, it is not one or the other.

Q. There would be a two-week period between the two; is that right, Doctor?

A. Yes. The normal gestation would be 40 weeks.

Q. When you speak of 26 weeks, that would be 24 weeks from conception?

A. The standard approach is L & P.

Q. The other term I wanted to make sure I understood is the term perinatal mortality.

What is perinatal mortality, Doctor?

A. It is the first 28 days after delivery. If the mother comes to the delivery room and the baby is alive at that time, and is delivered still-born, that would be included in perinatal mortality.

Q. In some texts the name neonatal mortality is stated. What is neonatal?

A. Neonatal would be 28 days after delivery.

Q. And perinatal would be when the fetus is in the mother's womb?

A. Yes.

Q. In those terms, what does survival mean?

A. Survival means past the first 28 days.

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Q. You would equate "survival" with the phrase that you have been using, "take the baby home"?

A. Yes.

Q. That would be a fair definition of that?

A. Yes.

Q. Now, Doctor, Judge Adams asked you some questions concerning gestational age, and where you would place viability in terms of gestational age; is that correct?

A. Yes.

Q. Let's assume the same 10 doctors standing around the table and examining the woman; would they reach the same conclusion in regarding gestational age, from their examination?

A. They would be very close in terms of the days.

Q. There is a margin of error in that estimate; is that right?

A. That's right. In making the judgment you take account.

Q. The testimony before was the range is plus or minus two weeks either way; would that be correct?

A. That's right. Given the same information, the doctors would come up with the same estimate.

Q. There would be a range of error, wouldn't there?

A. A range of error in the examination and history, and things like that.

Q. And additionally, in measuring or attempting to ascertain the approximate weight of the fetus, there are variables; is

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that correct?

A. Yes.

Q. Would nutrition be one?

A. Oh, yes; the health of the mother.

Q. What other kinds of variables go into it?

A. The presence or absence of diabetes in the mother. Diabetes is a common disease in the community.

The size of the previous baby in relationship to gestation, we use that as sort of an informal formula.

Q. When people discuss—when doctors discuss in papers the survival of infants or fetuses who have variable gestational ages, they discuss that in terms of periods of survival; is that correct?

A. That's correct.

Q. I might ask you this: are you familiar with Alden's, from the Department of Peditatrics, University of Washington—I am not asking you in detail—I am going to suggest a paper—

A. When was the publication?

Q. July, '72.

Based on a five- year experience, 160 infants with birth weights of less than one thousand grams, they found a mortality rate of 87 percent.

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Q. 161 infants under 1,000 grams they found an 87% survival rate?

A. 87% survival.

Q. Oh, I'm sorry, 1,000.

A. Yes, I think they took from 500 to 1,000, right.

Q. That's correct, yes.

A. And that's—you know, so that generally would include the two groups of babies we are talking about, 26 to 28.

Q. Now, when they went down to a sample—I'm sorry, I'm going to suggest another paper to you of a slightly earlier date, which Potter and Davis did analyze in Chicago's on prenatal mortality. That study ended in 1966 and they found what they determined survival of about 5% on a sample of weights from 400 to 1,000 grams.

Would that be in accordance with the experience?

A. Yes, yes, the experience at that time, and that sort of illustrates the point that we were talking about, the change in experience.

Q. It changes?

A. As the technology improves.

Q. As technology improves. Now, incidentally, those two; the Potter and Davis study and the Alden study were done at what could be described as optimum conditions, were they not?

A. Well, not Potter and Davis, no.

Q. Was that not a teaching hospital?

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A. Yes, well, it is, but they never had innotologists.

Q. In other words, 1966 was too early for that?

A. Yes. Well, they just got one in 1973 so they were a little bit further behind.

Q. So you might improve the first percent statistic today by some amount?

A. That's right.

Q. All right. Incidentally, among the variables which would go into the survival possibility, is the age of the mother one?

A. It is not really well established, but we have now a feeling that, you know, in terms of health, yes, age is important.

Q. Can you give me an idea, and I don't want to push you if you don't feel that you can draw conclusions, but is the date attempting to show anything about the relevance in the age, to the age of the mother, to the survival rate of the fetus at a given weight, and if so, what?

A. Yes. I don't think—no, I'm sorry. I can't really expand on that, but there are some—you know, our experience, you know, there are some young teenage mothers who come in and they have—you know, they had no prenatal care, and those kinds of things, and, yes, that is a problem, so in Cincinnati we pay particular attention to the teenage pregnancy in terms of nutrition, and we have a nutritional supplement program going on in the city which, you know, in Harlem it's been demonstrated to improve all those members we were talking about.

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Q. Okay. Excluding that variable and comparing a well-fed or nutritioned teenager with an equally nutritionally advantaged older woman?

A. Well, that's never really been done, not to my knowledge.

Q. Do you have any feelings as to which way the data will go on that?

A. I really don't. It would be interesting to see, you know, how well nourished the American teenager is as tested by pregnancy.

Q. Yes. Now, Doctor, given a surviving fetus, my question to you is can you give us some idea of what chance that surviving fetus will have of difficulties such as motor or mental retardation at various weight ranges?

A. Yes. The older studies, particularly studies done in Scotland, which were very careful, showed a disappointing, rather dismal neurologic outlook for very low birth weight infants and that's what Dr. Dillian wrote about when she examined that problem.

Q. Have you been able to improve that at all?

A. Yes, quite a bit. There have been three articles just in the last—oh, within a year now speaking of the improving prognosis of very low birth weight. By "very low birth weight," to mean either 1,000 grams or below, or 1500 grams or below. The most recent one was last month in 1974 and they talked about the baby below 1,000 grams—you know, the improving prognosis. I think they had 14—no, they had 197 total babies below 1,000 grams, and I think a 5.3% neurologic abnormality which, you know,

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has just dramatically improved over Dillian's data within Great Britain.

Q. What kind of a facility was that?

A. That's a teaching hospital. That's the College of London. They include babies not only born at their teaching hospital, but babies born outside of their teaching hospital; clinics, small delivery service, et cetera, so—but I think I remember—I don't remember exact figures,

but about half were inborn and half were born outside of the hospital.

Q. Were the ones that were born outside brought over to their facility?

A. Yes.

Q. So that at least shortly after delivery, the ones in that sample had the advantage of teaching hospital equipment?

A. Yes. They didn't say—I don't think they said at what time the transfer was done, but, yes, you would assume it was done fairly quickly.

Q. Now, coming back a moment, Doctor, to the survival rate, I am trying to understand what your definition of viability in terms of period of gestation relates to in terms of the language generally used, which we have agreed in percentage tables.

At what percent do you conclude or what survival percent do you conclude represents viability?

A. Well, I think, you know, opinions are formed, you know, including discussions with my peers and innotologists, and

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discussions with obstetricians, and I spend a lot of time in community hospitals, for instance, and so I am an optimist, and I would say that 10% chance of survival is not too bad, but I think in general, myself with the rest of the medical community, would accept 50%, you know, as a very—as a hard-nosed survival that is very good.

Q. Might there be some who accept a 45% timetable?

A. Yes. Then you would look at the data, from where it was, and which babies, for instance, had problems at delivery or had—you know, difficulty.

So there are other parts of that formula that determine a baby's survival, not just the gestation.

* * * *

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BY MR. MORRIS:

Q. Doctor, can you conceive of other doctors respected, whose opinion might be that viability in the sense used in the statute here could take place as early as 22 weeks?

A. Well, you know, we have discussed it and, you know, seeing the newspaper articles from Florida, or whatever, but, you know, a 20-week gestation baby surviving, and I think within the field

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that data is mistrusted, and it is not a reasonable thing. You know, with our current technology, it doesn't jive.

Q. I meant 22 weeks.

A. No, 22 weeks, no. That doesn't jive either. That's not acceptable data and it has never really been put up for peer review or peer criticism. It's newspaper crap. That's not acceptable.

Q. I am not speaking now of what you define as newspaper material. I am speaking of percentage tables indicating that increasing percentages of babies survive as the gestation period, to the extent you can determine accurate, that increases in age.

A. I think that's true, but my answer was in light of the current information, that the date you gave, the

22-week gestation baby, it's not reasonable that that baby survives. You know, everybody mistrusts that information.

Q. That is your opinion?

A. No, it is not.

Q. But what I am asking you is are there any doctors who would disagree with you on that or is it your testimony that all doctors would agree 100%?

A. Anybody knowledgeable in the field would disagree, and I think—well, I don't know Dr. Mecklenberg, and I don't know who he is, but my guess is that he is not a perienotologist.

Q. No, that is correct. He is an obstetrician and gynecologist, but obstetricians and gynecologists have experience in this field,

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do they not?

A. Experience. I don't think they set any of the standards. I think obstetricians and gynecologists who are leaders and more knowledgeable—you know, this is their field of interest, tend to set a standard, and I think among those people that data would be asked to be reviewed.

Q. All right. Let me ask you this, Doctor.

JUDGE ADAMS: I do have the testimony in question. I don't know whether it is helpful or not. If there is no objection, I will read it just so that there would be no disagreement.

MR. MORRIS: Thank you, sir. It would be helpful.

JUDGE ADAMS: It is at page 82, Dr. Mecklenberg, redirect.

"MR. MORRIS:

"Q. Doctor, as one who perform abortions, I want to read you a sentence and ask you what it means to you. The sentence is: 'Viability means capability of a fetus to live outside the woman's womb albeit with artificial aid.' I want to ask you at what stage of gestation you, as one who has performed abortions, would put that definition."

There was an objection, but then he answered:

"I would agree with that definition of viability. I think that it has been current. I think it is a definition that takes into account medical progress, the fact

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that it is constantly changing. My perusal of the medical literature would lead me to believe that potential or continued life exists as early as 20 weeks. Not in the current edition of Eastman's Obstetrics Book, but in the previous edition, the earliest report of survival was reported as a delivery at 20 weeks gestation. In my own experience, the earliest survival that I have had is a patient who was 21 weeks from the time of conception or 23 weeks from the first day of her last menstrual period. The child is a year and a half old and normal."

Now, do you want to ask a question?

BY MR. MORRIS:

Q. Would you be in agreement with that answer, Doctor?

A. Yes, I think I know one of the reasons why it was withdrawn from Eastman's textbook—you know, the claim for a 20-week survival. There has been more attention paid to, you know, more accurate gestational assessment and, you know, current information, and I think that was withdrawn because it doesn't, you know, really make very much sense currently and would be suspect.

Q. So I take it what he cites was suspect, the data on which he relied?

A. Yes.

Q. Doctor, taking the example posed by Judge Adams again where we have a patient that we are examining, but the fetus has

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not yet been delivered on the table, is there any way that you can tell with certainty whether that particular fetus in that particular mother is or is not, will or will not survive, or is or is not viable?

A. Well, you know, assessing the gestation by the methods that we talked about, coming up with a reasonable estimate of gestation, and then again, you know, part of that formula for assessing viability, current experience both, you know, within and without the community, but mostly within, is the important determinant.

You know, yes, I think people in the field will come up with a reasonable medical judgment that the baby will survive and go home. Be it viable or not, I don't know.

Q. Will they do that based on percentage chances?

A. Oh, yes. That would be part of the formula, yes.

Q. Isn't that what you have done in reaching your conclusion; related gestational age to percentage chance of survival?

A. No, but you are asking me in individual cases and that would have to take in some of the other things that we talked about; infection, you know, how well the mother has done; all those other things. So admittedly it is a soft—it begins to be soft, but that is the way medicine is. That is the practice of medicine. There are a lot of things that—

Q. What do you mean by it begins to be soft? Begins to be questionable?

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A. No. It's hard to define in a textbook exactly how you will do it so it covers all cases. There are a lot of things that come into the judgment there that you have to take into account.

Q. I want you to assume that the patient on the table is nutritionally advantaged and healthy in all respects and that the background is unexceptional.

A. Background of what? Of the mother's health?

Q. That the background of the mother is unexceptional in terms which will be significant to you.

A. Okay.

Q. And what I want to understand is how would, that mother presented in that fashion, the examining doctor or doctors be able to do any more than suggest a possible percentage chance that that fetus might have while it was still in the womb.

A. Yes. Well, I think you would start with the percentage. I would agree with you and then on top of that is the mother bleeding or not bleeding; did she have a

premature baby that survived or did she have a premature that didn't survive.

Q. Let's assume none of those things. Unexceptional.

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BY MR. MORRIS:

Q. Let's assume none of those things are exceptional; that would alter the percentage chance, would it not?

A. Not in finding percentage, but it would alter the percentage chance.

Q. You are looking at a table of percentages and you are making some judgment that a 50 percent or 40 percent or 60 percent we will decide that that particular fetus will survive outside the woman with artificial aid; is that correct?

MRS. MANSMANN: I think the witness said he takes into consideration many factors based on this particular patient. As a result, the question as phrased is not based on the testimony.

MR. MORRIS: Can you answer the question?

A. I was going to answer it. All kinds of other things come into play in that situation.

Q. Even after you ascertained every variable you still are faced with a percentage chance of survival or not survival; is that correct?

A. If you divide by a denominator, it is a percentage.

Q. Wouldn't I be fair in saying that an obstetrician or gynecologist faced with the problem of determining while the fetus is in the womb whether that particular fetus is viable, it is really a quick-chance situation, it's soft; is that correct?

(p. 571)

A. It's soft. Like most other things we do and come up with a reasonable estimate, you do the best you can.

Q. The way we are talking here is not the way the doctors think; the way the doctors think is percentage chance and a lot of things; is that correct?

A. Well, in Cincinnati, I work with experimental psychologists. They are appalled at the way we make decisions. There are so many variables that are poorly defined.

They think it should be yes or no or zero or one hundred. That is the way they do things. They have rats, and they think things out.

We don't do it that way.

Q. In the case we are talking about it's not yes or no; it's a possibility?

A. Not yes or no. In terms of percentage you come up with a reasonable chance and not a reasonable chance.

Q. In areas like that, isn't it true that reasonable men can disagree?

A. I have read that.

Q. Isn't it true in your experience?

MRS. MANSMANN: I will object to that, Your Honor. He will have to clarify that by using "reasonable degree of medical certainty."

My objection is to the question as phrased. It goes to the point of "reasonable men." The question should

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be more properly phrased, "reasonable degree of medical certainty."

JUDGE ADAMS: We will sustain the objection.

Rephrase the question, Mr. Morris.

BY MR. MORRIS:

Q. Doctor, isn't it true that among ten doctors discussing this case, the discussion will present opposing points of view?

A. I don't think so.

Q. You think they will all agree?

A. There will be substantial agreement. I don't have any experience—it just seems to be that is the way things are practiced. They change.

What I expect of a doctor in Green County is not the same as I would expect from a doctor in my hospital, exactly.

Q. Say that again, please.

A. I would expect patient-care to be in Green County Hospital—I think that is a good hospital, with reasonable men, as you mentioned—when I go out there we talk about problems. We don't disagree substantially.

If I give them any new pieces of information they'll say, "That's great. We'll see if we can use it."

Q. Doctor, when you are putting variables together there is disagreement as to what the individual judgments are; is that correct?

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A. There's always room for differences, but I think everybody in conclusion can see the other person's differences. They'll say, "Yes, I will do it this way."

Q. Let's suppose that you have reached a point, in your opinion, where a particular fetus may be viable and

you desire for some reason to give the fetus the best possible chance of survival, consistent with the health of the mother, what would your methods of delivery be, of choice?

A. That is more an obstetrician's decision. He is part of the perinatal team.

They may ask me about a drug. I don't deliver babies. I don't know.

Q. Let's assume the fetus is 1200 to 1300 grams, and you wanted to try to encourage survival, would you use a prostaglandin infusion and C-section?

MR. MANSMANN: I must object to that, Your Honor. The witness stated that this is out of his expertise.

JUDGE ADAMS: Are you able to give an opinion in response to the question?

A. In our team approach I defer that decision to the obstetrician.

BY MR. MORRIS:

Q. Do you have any idea what the decision would be?

MRS. MANSMANN: I object to that question. The question as phrased by Mr. Morris doesn't determine

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whether or not a method is better for the mother with respect to the risk factor. The question as phrased very simply does not consider the factors defined in the Act.

JUDGE ADAMS: Do you press the objection?

MRS. MANSMANN: Yes, I do, Your Honor.

JUDGE ADAMS: The objection is overruled.

MS. LEADBETTER: I have a slightly different objection, Your Honor.

I might ask that the question be read back. The question did not include that this is a situation where a decision for abortion has been reached.

I am not certain that we are clear we are talking about abortion techniques as opposed to delivery techniques.

JUDGE ADAMS: I have a feeling that Mr. Morris is going to rephrase the question.

MR. MORRIS: Yes, Your Honor.

BY MR. MORRIS:

Q. Doctor, am I correct in assuming that the best chance of a surviving fetus is to carry it to term?

A. That is not always true.

Q. Is it true in the normal case?

A. Yes.

Q. Let's assume the normal case; assume that we are going to remove the fetus from the woman at 12-to-13 hundred grams;

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assume we also desire to protect the life of the mother consistent with the fact of the removal of the fetus from the womb; would the obstetrician on your team elect a prostaglandin infusion or a C-section?

A. They use both. That is not my decision.

Q. What do you see most?

A. In my experience they never do the normal case. I guess that answers your question.

Q. Doctor, I am going to read a section from the Act, and ask you if you can help us with this section. If it's not within your area of expertise, please tell us.

This is Section 5a. (Reading)

"Every person who performs or induces an abortion shall prior thereto have made a determination based on his experience, judgment or professional competence that the fetus is not viable; and if the determination is that the fetus is viable, or if there is sufficient reason to believe that the fetus may be viable, shall exercise that degree of professional skill, care and diligence."

MRS. MANSMANN: Your Honor, for a witness who has not seen that before that is pretty hard to swallow. I suggest that he may read it before he answers the question.

JUDGE ADAMS: Give him a copy of that to read.

BY MR. MORRIS:

Q. Read Section 5a, Doctor.

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(Handing document to witness.)

THE WITNESS: Can I have a minute to read this?

JUDGE ADAMS: Surely.

BY MR. MORRIS:

Q. Let me ask you whether you have had a chance to read that, Doctor?

A. Yes. In my area of expertise there are obviously—there are things done by management in the pregnancy that does not influence the health of the baby.

In terms of the delivery selected in this instance, I don't think I am qualified to answer.

MR. MORRIS: That is all, sir.

THE COURT: Any further questions of this witness?

MS. WALLIS: I had a couple of questions, Your Honor.

MR. MANSMANN: I was going to ask some more questions, but I will let Ms. Wallis go ahead.

JUDGE ADAMS: Mr. Mansmann is deferring to you, Ms. Wallis.

Cross-Examination

BY MS. WALLIS:

Q. Doctor, can you tell us what period of gestation you would say the fetus is "presumably capable of meaningful life"?

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A. In those babies I talked about, 50 percent and 75 percent in our experience.

Q. Do those babies almost all do very well and are capable of meaningful life?

A. If you take care of the very small baby, I think they will do very well.

I think that the concern is very much tempered with the information available.

Q. If you add the percentage of severe brain damage to the percentage related to survival, at what point in gestation would you say you could determine that a fetus would be "presumably capable of meaningful life"?

A. Going back to the same babies with neurological disability, some of them are severely affected. There were five out of a hundred that were retarded.

That means that 95 out of a hundred were not. Given that information, I would say that baby falls into that group.

Q. Would you say that a fetus of 28 weeks' gestation would be presumably capable of meaningful life?

A. 26, 28.

MS. WALLIS: I have no further questions.

Redirect Examination

BY MR. MANSMANN:

Q. Doctor, Ms. Wallis talked to you about motor and mental

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deficiencies.

Will you tell the Court what causes those deficiencies in the premature infant?

A. It is prematurity, per se. There are vunerabilities in the methods of delivery. If the mother is sick the baby may have an infection. The baby may have a low APGAR score. A lady in New York devised a scoring system. That goes to how the baby does after delivery.

It seems to be more concerned around the birth of the baby. There is the delivery of oxygen and the concern for early nutrition, and keeping the baby warm. It is the very simple things that mothers know what to do.

I am sort of a substitute mother. The thrust of my specialty is preventive medical care. That is defined by many people. I have the opportunity to supply the baby with the things he needs, so that he continues to grow and develop and do well. The figure cited when they picked out the variables, that seemed to be important in the baby's progress.

Q. That would be the physiological reason for the motor deficiencies of retardation?

A. Yes.

Q. Has any progress been made as far as the prevention or cure of this problem?

A. There is lots of progress in prenatal care as to

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nutrition.

I mentioned the program we have in Cincinnati for better nutrition before the baby is born. These babies are healthy. We pay a great deal of attention to the baby's nutrition, even in the first week of the delivery. There is lots of information coming up concerning nutrition.

The area of oxygenation, that is fraught with technology. There is an awful lot going on. In the five years that I have [been a] perinatologist, there is fantastic technology in oxygenation. It has become so sophisticated in levels of management. In keeping the baby warm, one of the research programs is looking at methods in keeping the babies warm and how they relate to the baby's health. We have made tremendous advances in the last three years.

I think there is going to be lots of changes in this field. I talked about the expanding concept.

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TESTIMONY OF ARTURO HERVADA, M.D.,
TAKEN JANUARY 17, 1975

* * * *

BY MR. MANSMANN:

Q. Doctor, we have heard from Dr. Keenin and I believe you were in the courtroom for part of it?

A. Yes.

Q. As to the methods that were utilized generally in ascertaining whether or not a particular fetus is viable.

Because that has been covered already, we are not going to ask you to discuss that in detail, but what I would like you to do is to direct your attention and give us the benefit of your opinion and experience as to the gestational age as to when a particular fetus would, in fact, be viable.

Could you tell us at what gestational period you would—

A. Well, I guess because you are talking about Dr. Keenin's type of facts and figures, I think that is what makes me very uncomfortable is the temporality of all of our statements.

Q. When you say temporality of your statements, what are you talking about?

A. I am talking about, you know, that we are talking about medicine. This is not a complete science. We are continually changing and it is, therefore, a total need of

(p. 583)

people to understand that what I say today, please don't quote me tomorrow because the fantastic progress of medicine is such that, you know, we have witnessed things that we would never have assumed would happen and, therefore, I think that at this moment you have to be careful because I am a biologist and there is a temporality, a desparate necessary temporality in all these statements, and when you are trying to make laws, it makes me very uncomfortable because, as a biologist, what I say today, I may have to swallow tomorrow.

Therefore, on the knowledge of today and on the understanding of this temporality of what I say, I think when we are talking about 28 weeks survival, I am also very uncomfortable. We are obsessed with figures. You are obsessed with statistics. They might be marvelous for an engineer doing houses. I am talking about lives.

You are obsessed with so much percent; what about 5 percent to survive, or do you want to let five children percent die; how many percents.

Do you have a hangup with statistics and it makes me very uncomfortable because statistics and medicine don't blend.

You see we are a very inadequate science. We are an art and you want me to be a computer. I can't.

Therefore, to be talking about 28 weeks, you want an argument about, I think with our knowledge of

(p. 584)

28 weeks and the mother, what is her age, what is her race, what care has she got, what is her nutrition? I have to ask a lot of things.

Q. So that if a law said 28 weeks, without any other type of qualifications, you would be very uncomfortable with that particular law; is that right?

A. Indeed.

Q. And the reason for that is the expanding concept?

A. Sure. The continuous, you know, progress of medicine, and also let me tell you something. The incredible times in the past that we have been wrong. You know, maybe that is unusual for a physician to say that but that is a fact.

Q. So that if a gestational age alone were utilized as a test of viability—

A. How do we measure it? You know, we have—we can put a man on the moon, but we haven't got the foggiest idea how long this lady has been pregnant. You know, we have so far not very accurate—scientifically accurate data and we go on when was your last menstrual period, your size. You know, we can measure in one drop of blood 20 samples of 20 different parameters, but we cannot know by certainty, to my knowledge, how long a lady actually has been pregnant.

Q. And so this is a reason for your feeling uncomfortable with setting 28 weeks definitely at this particular time?

A. Yes.

(p. 585)

Q. Do you agree with Dr. Keenin that the point of viability at the present state of medical art is at 28 weeks?

A. Will you repeat that again?

Q. Do you agree with Dr. Keenin that viability, considering the present state of medical art, is at 28 weeks gestation?

A. 20?

Q. No, I said 28.

A. 28, yes.

Q. At 27?

A. Yes.

Q. And would you expect any disagreement among physicians as to that opinion?

A. I would think so, but I also would like to make very clear, you always seem to find disagreement here. I have the feeling that we doctors disagree on everything so, therefore, when you pose to me ten doctors will agree, I don't know. Maybe I work in a very paranoid place, but the place I work no ten doctors would agree on anything.

Therefore, you know, this is oversimplication. When you get ten doctors to agree with you, I am sure you can get ten doctors to disagree in Philadelphia in a court.

Q. Would you expect ten doctors to disagree with you that viability at the present state of medical art is at 28 weeks?

A. Probably not, but most of them would agree with it, but this is, you know, medicine.

(p. 586)

I am sure if they are well informed, they will agree that the fetus is viable, but the human element, and so on, you know, the enterologist will not disagree; a real specialist in that field, which is what counts, because there are all kinds of doctors. The expert, probably not.

Q. Or a more informed physician would disagree with you?

A. Yes. An obstetrician, a person who works in that field now.

Q. And, Doctor, you have talked about the fact that if you said 28 weeks today, you don't want to be quoted tomorrow on that?

A. No way. No, I don't want to be quoted about anything.

Q. I know. Nobody wants to be quoted about anything.

A. Medically, no. Medically you will have troubles with, for instance, you or with us. You know, it is very interesting that I can give a patient of mine a medication that will have the first wrong side effect and I didn't know it. They will take me to court and they will collect a fortune out of that and I didn't have any idea that it was going to happen and you want me to be quoted? No, sir.

This is an art. You know, I cannot measure by logical standards. If you get me into biology, yes. This is very vulnerable. You know, we teach medical students, but what we teach them today in five years is gone and if they haven't read, they are behind.

(p. 587)

Q. So that you are concerned about setting anything that would be too high at the present time than in the future. Is it your opinion that viability is going to be at a lower gestational age than it is presently in the future?

A. It has to improve only in one way, which is shorter and shorter gestational age. Obviously it cannot

be the other way, and what would be right today—you know, I would be very, very uncomfortable as a biologist because of the temporability of our knowledge.

Q. And so if we said that 28 weeks today, you are concerned at three months from now there will be babies who are definitely viable at 24 weeks; is that your opinion?

A. Yes. Sure.

Q. And is that the reason for your feeling uncomfortable with setting it at 28 weeks, for example?

A. Yes.

Q. And it is because of the expanding concept lowering the point of viability?

A. The internal and, hopefully, continuous improving of medical knowledge. We are doing things, you know.

If you get a doctor that expired 50 years ago, and I will get him back on this earth, and I will take him to our hospital and he would make rounds with us, he would be absolutely lost. He would have no idea of what we are talking about, the language, the medications, the machines.

(p. 588)

For him they would be totally unknown. He would be absolutely as lost as anything and I talk to you only 50 years ago.

Q. Doctor, when you are talking about physicians being not a statistical or medicine not being a statistical science, you do use reasonable medical judgment; is that right?

A. Yes.

Q. And there are certain standards that are prevalent in a medical community; is that correct?

A. Yes.

Q. And if physicians measure up to that particular medical judgment and medical procedure, they would be practicing good medicine in your opinion; is that right?

A. Yes.

Q. And you would expect other physicians who are of the same medical community to agree with you that that was good medical care?

A. I would hope so.

* * * *

(p. 592)

BY MR. MORRIS:

Q. Doctor, let me ask you this: Would you consider the word "viable" in its practical application inaccurate and imprecise?

A. That is the practical indication.

Q. By "practical," when you are attempting to determine if a fetus is viable while still in the mother, would it be an imprecise and inaccurate word?

A. When a fetus is able to survive it is. I think they are two different words.

Q. Can you tell us: while the fetus is in the mother, is it viable?

A. No.

Q. Do you know if obstetricians and gynecologists regard it as viable?

A. With a certain degree of accuracy, but not with the measurement with exactitude. We can't tell you at this moment. You have 14 grams of hemoglobin in your blood. I don't have that experience. This is human error and human art and not published. The blood has

so much to put in that machine. When the blood is put in that machine it is one tenth of a gram. I am not an obstetrician; I am a pediatrician.

MR. MORRIS: No further questions.

JUDGE ADAMS: Ms. Wallis.

(p. 593)

BY MS. WALLIS:

Q. Doctor, questions have been posed to you as to how you would estimate viability based on survival.

How do you understand the word "survival"? In previous testimony we talked about perinatal mortality, neonatal mortality and survival after 28 days. Is that the way you are using the term?

A. I am using it from the moment the child is discharged from the hospital. That baby is in the statistics. In the neonatalogy the mortality is 28 days. That's a survival rate.

There are 10, 12 countries in the world that have babies that survive more than our babies of survival. When you define statistics, we don't mean the whole life of the child, to my knowledge. The other countries are accusing us of infant mortality.

Q. As you used the word a minute ago, survival is 28 days?

A. In that context, yes.

Q. That's in the context of making a determination with respect to viability?

A. Those are the ones we have.

Q. As far as you are concerned viability means the capability of the fetus to survive for more than 28 days after birth, albeit with artificial aid?

A. To survive, if you are talking about natology that is 28 days.

* * * *

(p. 595)

Q. What I am trying to determine is whether the words "to live," as it is used in this definition, is a term literally clear to the doctor, or the one doctor might think "live" means to be alive after birth; to another doctor it might mean being alive immediately following birth; and another doctor thinks it means to be alive in the womb, even though it might not be able to survive more than an instant in the atmosphere of the outside world.

A. Number one, to live I understand outside the womb; number two, it will be difficult to be a productive, normal adult. We have to go day by day.

Q. Would you say all those possibilities exist?

A. To live one day, he may die after one day.

Q. Do I understand that your answer was "yes" to that question?

A. To live outside the uterus.

MS. WALLIS: I have no further questions.

JUDGE ADAMS: Are there any other questions of the physician?

MR. MANSMANN: I have one more question, Your Honor. My wife answered that for me.

Redirect Examination

BY MR. MANSMANN:

Q. Doctor, when you are talking about determining viability, you expect a physician to use his experience, judgment and

(p. 596)

professional competence in arriving at that decision; is that correct?

A. Yes.

Q. If you did that you would expect the other physicians would agree with him?

A. Yes.

MR. MANSMANN: That is all, Your Honor.

JUDGE ADAMS: Thank you very much, Doctor.

We appreciate your testimony.

You may call the next witness, if there is one.

MRS. MANSMANN: For the purposes of the record, Your Honor, I would like to read as admissions statements from the deposition of Dr. Andros, which was held on November 20, 1974; and who is identified as president of the Obstetrical Society of Philadelphia.

I am reading at page 32.

(Reading) "Q. So it is your understanding that viability is the ability of the fetus to live outside the mother's uterus?

"A. Correct.

"Q. Do the words 'with artificial aid' confuse you?

"A. No, they do not confuse me. I believe that this is a trueism, just like in serious adult diseases, such as stroke, so forth.

(p. 597)

"Q. Explain that to me? I don't understand what you are talking about.

"A. It is possible for a patient to have serious —an adult patient or a child to have serious brain damage from injury, say, that it is incompatible with survival, unless artificial means of cardio-pulmonary assistance is given.

"Q. And the area we are talking about, when we are talking about the viability of fetuses, we are talking about artificial aid to keep the fetus or give the fetus a chance to survive; is that right?

"A. That's right."

MR. MORRIS: Continuing on page 34 of the deposition:

(Reading) "Q. And how do you determine whether or not a fetus is viable, generally?

"A. At the moment, there is no good test for that, except by—you cannot—there is no good test or diagnostic aid to tell whether the lungs are capable of expanding and maintaining cardio-pulmonary function.

"Q. Don't you really base that on statistics and your experience as a physician, and on the clinical history you receive from the patient?

"A. And the physical findings of size of the baby, et cetera, et cetera. There is no good test for

(p. 598)

determining.

"Q. There is no absolute test?

"A. Right.

"Q. And the point of viability may differ with each particular fetus?

"A. And the condition of the fetus. An infant of, or a fetus of, let's say, 28 weeks, may conceivably eventually survive on its own, but that is very—to me the lower limits, perhaps.

"Q. Of course, that is always lowering it, too, isn't it, the limit of survival of gestational age?

"A. Lowering?

"Q. Right.

"A. No, I am not entirely convinced it can be lowered to infinity or anything like that.

"Q. I am not, either, and I don't think anybody is.

"A. Because we do not have—we cannot determine—there is no way to make lungs, to a certain degree immature, to expand and stay expanded."

MRS. MANSMANN: Which brings me to the section I was going to read:

(Reading) "Q. But this is a developing area in the medical field; right?

"A. Definitely.

(p. 599)

"Q. And that is the neonatalogist's area; isn't it?

"A. Right, that is correct.

"Q. So if I told you as a physician, assuming I had authority to do so, if I told you as a physician that you could not perform an abortion after the point of viability, you would know what I was talking about, wouldn't you?

"A. I would know what you were talking about in general, but—

"Q. You would have to apply that to each particular case, wouldn't you?

"A. Yes.

"Q. And you would have to use your medical judgment to that?

"A. That is correct."

Mr. Morris got ahead of me on one section here, when he jumped ahead to page 36. Oh, yes.

(Reading) "Q. And we are not asking the point of viability; it may differ with each particular fetus; is that right?

"A. That is correct."

MR. MORRIS: I have to continue.

(Reading) "Q. And perhaps a fetus is viable at 24 weeks, perhaps it is viable at 28 weeks; is that right?

(p. 600)

"A. Perhaps. I do not believe that a fetus is viable at 24 weeks, if it is actually 24 weeks' gestation.

"Q. That is a problem, isn't it, to figure actually what the gestation age is?

"A. That is correct."

MRS. MANSMANN: Then we read the rest of that, Your Honor.

Now I would like to read from Dr. Franklin's deposition, page 39.

(Reading) "Q. Doctor, your lawsuit, of course, has attacked the definition of the word "viability" as it is used in the Act.

"A. Yes.

"Q. And you are familiar with what the Act says?

"A. Correct.

"Q. Could you tell me what your definition of the word viability is?

"A. Viability to me means that the baby has a probable chance, we'll say, ten percent or better, of survival with the equipment and skills of an average hospital in this country.

"Q. So viability to you means, I assume, means the ability of the fetus to survive?

(p. 601)

"A. Right.

"Q. Outside the mother's womb?

"A. Right."

* * * *

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 74-2440

Planned Parenthood Association of Southeastern Pennsylvania, Inc., et al.

Plaintiffs

vs.

J. Emmett Fitzpatrick, Jr., District attorney of Philadelphia County

and

Helene Wohlgemuth, Secretary of Welfare of the Commonwealth of Pennsylvania

Defendants

DEFENDANTS' EXHIBITS W, X, Y and Z

DEFENDANTS' EXHIBIT W

Commonwealth of Pennsylvania County of Philadelphia

I, J. EDWARD LYNCH, M.D., having been first duly sworn according to law hereby depose and say that:

1. I am a physician licensed by the Commonwealth of Pennsylvania. I have been certified by the American Board of Obstetrics and Gynecology and am currently in private practice in the Philadelphia area and I am on the

staffs of Mercy Catholic Medical Center and Jefferson Hospitals. In the course of my practice I have performed surgical procedures. A true and correct copy of my *curriculum vitae* which states my education, professional affiliations and experience is attached to this affidavit as Exhibit A.

2. I have been provided with a copy of the Abortion Control Act of the Commonwealth of Pennsylvania and am familiar with the fact that the Act uses the word "viable" and that it is defined in Section 2 of the Act as meaning ". . . the capability of a fetus to live outside the mother's womb albeit with artificial aid."

3. The word "viable", as defined in the act, is consistent with the way I use, understand and have understood the word in my practice as a physician. Furthermore, in my opinion, "viable" as defined in the statute comports with the standard medical definition and is consistent with how my medical colleagues, who practice in the Philadelphia area understand this term.

4. During the course of my practice and as is in the case of any practicing obstetrician-gynecologist, I frequently have occasion to determine the viability of a fetus. I make this determination based upon the history which is reported to me by my patient, my clinical examination, and my medical judgment. The medical procedure for determining the viability of the fetus is a relatively uncomplicated procedure.

5. I am a member of the Philadelphia Obstetrical Society which, I am informed, has intervened as a plaintiff in this lawsuit. My prior consent to the Society's intervention was not sought nor have I been notified of the intervention by the Society.

[Signature omitted in printing]

DEFENDANTS' EXHIBIT X

Commonwealth of Pennsylvania County of Philadelphia

I, EDWARD M. SULLIVAN, M.D., having been first duly sworn according to law hereby depose and say that:

1. I am a physician licensed by the Commonwealth of Pennsylvania. I have been certified by the American Board of Obstetrics and Gynecology and am currently in private practice in the Philadelphia area and I am on the staffs of Mercy Catholic Medical Center and Riddle Memorial Hospitals. In the course of my practice I have performed surgical procedures, but I have not performed any abortions. A true and correct copy of my *curriculum vitae* which states my education, professional affiliations and experience is attached to this affidavit as Exhibit A.

2. I have been provided with a copy of the Abortion Control Act of the Commonwealth of Pennsylvania and am familiar with the fact that the Act uses the word "viable" and that it is defined in Section 2 of the Act as meaning ". . . the capability of a fetus to live outside the mother's womb albeit with artificial aid."

3. The word "viable", as defined in the act, is consistent with the way I use, understand and have understood the word in my practice as a physician. Furthermore, in my opinion, "viable" as defined in the statute comports with the standard medical definition and is consistent with how my medical colleagues, who practice in the Philadelphia area understand this term.

4. During the course of my practice and as is in the case of any practicing obstetrician-gynecologist, I frequent-

ly have occasion to determine the viability of a fetus. I make this determination based upon the history which is reported to me by my patient, my clinical examination and my medical judgment. The medical procedure for determining the viability of the fetus is a relatively uncomplicated procedure.

5. I am a member of the Philadelphia Obstetrical Society which, I am informed, has intervened as a plaintiff in this lawsuit. My prior consent to the Society's intervention was not sought nor have I been notified of the intervention by the Society.

[Signature omitted in printing]

DEFENDANTS' EXHIBIT Y

Commonwealth of Pennsylvania County of Philadelphia

I, ANDREW A. SULLIVAN, M.D., having been first duly sworn according to law hereby depose and say that:

1. I am a physician licensed by the Commonwealth of Pennsylvania. I have been certified by the American Board of Obstetrics and Gynecology and am currently in private practice in the Philadelphia area. In the course of my practice I have performed surgical procedures, but I have not performed any abortions. A true and correct copy of my *curriculum vitae* which states my education, professional affiliations and experience is attached to this affidavit as Exhibit A.

2. I have been provided with a copy of the Abortion Control Act of the Commonwealth of Pennsylvania and am

familiar with the fact that the Act uses the word "viable" and that it is defined in Section 2 of the Act as meaning ". . . the capability of a fetus to live outside the mother's womb albeit with artificial aid."

3. The word "viable", as defined in the act, is consistent with the way I use, understand and have understood the word in my practtice as a physician. Furthermore, in my opinion, "viable" as defined in the statute comports with the standard medical definition and is consistent with how my medical colleagues, who practice in the Philadelphia area understand this term.

4. During the course of my practice and as is in the case of any practicing obstetrician-gynecologist, I frequently have occasion to determine the viability of a fetus. I make this determination based upon the history which is reported to me by my patient, my clinical examination, and my medical judgment. The medical procedure for determining the viability of the fetus is a relatively uncomplicated procedure.

5. I am a member of the Philadelphia Obstetrical Society which, I am informed, has intervened as a plaintiff in this lawsuit. My prior consent to the Society's intervention was not sought nor have I been notified of the intervention by the Society.

[Signature omitted in printing]

DEFENDANTS' EXHIBIT Z

Commonwealth of Pennsylvania County of Philadelphia ss

I, JERRY F. NAPLES, having been first duly sworn according to law hereby depose and say that:

Defendants' Exhibit Z

1. I am a physician licensed by the Commonwealth of Pennsylvania. I have been certified by the American Board of Obstetrics and Gynecology, am currently in private practice in the Bucks County, Pennsylvania area and am on the staffs of Lower Bucks St. Mary's and Temple University Hospitals. In the course of my practice I have performed surgical procedures. A true and correct copy of my *curriculum vitae* is attached to this affidavit as Exhibit A.

2. I have been provided with a copy of the Abortion Control Act of the Commonwealth of Pennsylvania and am familiar with the fact that Section 2 of the Act uses the word "viable" and that it is defined to mean ". . . the capability of a fetus to live outside the mother's womb albeit with artificial aid."

3. The word "viable", as defined in the Act is consistent with the way I use, understand and have understood the word in my practice as physician. Furthermore, in my opinion, "viable", as defined in the statute, comports with the standard medical definition and is consistent with how my medical colleagues, who practice in the Philadelphia area, understand this term.

4. During the course of my practice and, as in the case of any practicing obstetrician-gynecologist, I frequently have occasion to determine the viability of a fetus. I make this determination based upon the history which is reported to me by my patient, my clinical examination, the use of medical statistics and my medical judgment. The medical procedure for determining the viability of the fetus is a relatively uncomplicated procedure.

[Signature omitted in printing]

Findings and Conclusions of Law

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 74-2440

Planned Parenthood Association of Southeastern Pennsylvania, Inc., et al.,
Plaintiffs

vs.

J. Emmett Fitzpatrick, Jr.,
District attorney of Philadelphia County
and
Helene Wohlgemuth, Secretary
of Welfare of the Commonwealth of Pennsylvania
Defendants

PLAINTIFFS' REQUESTS FOR FINDINGS OF FACT AND CONCLUSIONS OF LAW AND DEFENDANT COMMONWEALTH'S AND DEFENDANT FITZPATRICK'S RESPONSES THERETO

102. Dr. Franklin does not believe it likely that a fetus at 25 weeks' gestation would survive.

Commonwealth: Admitted insofar as it reflects Dr. Franklin's opinion or belief.

Fitzpatrick: Admitted that these may be Dr. Franklin's opinions.

103. In Dr. Franklin's opinion, the chances for survival do not become probable until 28 weeks.

Commonwealth: Admitted insofar as it reflects Dr. Franklin's opinion or belief.

Fitzpatrick: In Dr. Franklin's opinion, the chances for survival do not become probable until 28 weeks.

106. Dr. Franklin believes he can make some judgment with respect to viability but that there is a high probability of error in any such judgment, to such an extent that he would expect a close colleague to disagree with it and would not be surprised by such disagreement.

Commonwealth: Admitted that such is Dr. Franklin's belief, however, it is not accurate or legally relevant.

Fitzpatrick: Admitted that these may be Dr. Franklin's opinions.

130. In Dr. Gerstley's opinion, fetuses do not reach the point of viability at exactly the same time and differ by a variance of approximately plus or minus two weeks in gestational age.

Commonwealth: Admitted.

Fitzpatrick: Admitted that these may be Dr. Gerstley's opinions.

131. On some eight or ten occasions during Dr. Gerstley's practice, he has been involved in cases where there was a question as to whether the fetus involved was viable.

Commonwealth: Admitted.

Fitzpatrick: Admitted that these may be Dr. Gerstley's opinion.

134. In Dr. Gerstley's opinion: When physicians make an assessment of viability, they try to determine when the last period was, if it was a normal period, if it was not, when was the last normal period, how does this patient have periods, to try to determine when she actually got pregnant, because physicians are dealing on one hand with weeks amenorrhea and weeks gestation. That can apply to the determination of viability, and then other medical factors such as disease or illness that may have skewed these dates one way or the other may apply, and then physical examination is made to determine the size of the uterus and how it fits in with any known disease that that patient may have or how the size of this uterus then fits in with the weeks amenorrhea, weeks gestation, to determine as best physicians can the size of the fetus, and from those factors, physicians interpolate on a scale the chances of the fetus surviving.

Commonwealth Admitted.

Fitzpatrick: Admitted that these may be Dr. Gerstley's opinions.

135. In Dr. Gerstley's opinion, the margin of error in determining periods of gestation is about four weeks.

Commonwealth: Admitted.

Fitzpatrick: Admitted that these may be Dr. Gerstley's opinions.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 74-2440

Planned Parenthood Association, et al.,
Plaintiff

Obstetrical Society of Philadelphia,
Intervenor Plaintiff

vs.

F. Emmett Fitzpatrick, Jr., and Frank S. Beal,
Defendants

and

Robert P. Kane and The Commonwealth of Pennsylvania,
Intervenor Defendants

OPINION

Before ADAMS, *Circuit Judge* and *NEWCOMER* and GREEN,

District Judges.

(Filed September 4, 1975

GREEN, *District Judge.*

This action comes before this Court upon a complaint challenging the constitutionality of the recently enacted Pennsylvania abortion statute, titled the "Abortion Control

Act,"[1] Act No. 209 (P.L.)[2]. Plaintiffs contend that the overriding purpose and dominant effect of the statute under attack is to discourage and interfere with certain clearly defined, constitutionally protected rights of the plaintiffs. Thus, they claim the statute should be invalidated in its entirety, despite the presence of a severability clause. Plaintiffs seek declaratory and injunctive relief pursuant to 42 U.S.C. §1983 and jurisdiction is invoked under 28 U.S.C. §1343.

On September 26, 1974, a three-judge court was designated on plaintiffs' application and pursuant to 28 U.S.C. §2281. Oral argument on the plaintiffs' application for a preliminary injunction was heard on October 9, 1974, and a preliminary injunction was entered on October 10, 1974, which enjoined the enforcement of Sections 3(b)(i), 3(b)(ii), 3(e), 5(a), 5(d), 6(b), 6(c) except as it requires a licensed physician to perform an abortion within the Commonwealth of Pennsylvania, 6(d), 6(i) except as it relates to 6(f), 7, and the definitions of "viable" and "informed consent" in Section 2. Also on October 10, 1974, this Court granted leave to the Obstetrical Society of Philadelphia to intervene as a party plaintiff.

On December 4, 1974, the plaintiffs filed a motion seeking a class action determination. Physician plaintiffs contended that the members of the proposed class "included, not only physicians who regularly perform abortions, but also those who may, in the course of their practice, be called upon to counsel their patients with regard to the option of abortion, which necessarily includes vir-

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[1]The Act was enacted over the Governor's veto on September 10, 1974 and took effect on October 10, 1974.

[2]35 P.S. §6601 et seq.

tually all physicians who practice in the Commonwealth of Pennsylvania." Plaintiffs also contended that the members of the proposed sub-class included board-certified obstetrician-gynecologists, who were members of the Obstetrical Society of Philadelphia, and who maintained their medical practice in Pennsylvania. The physician class plaintiffs allege that enforcement of the Abortion Control Act would "abridge their constitutionally protected rights: (1) to practice medicine in a manner consistent with the highest standards of their profession, (2) to be protected from unconstitutional intrusion of the physician-patient relationship in the decision making and treatment of pregnancy, and (3) the rights of their patients to terminate pregnancies under the conditions set forth in the Supreme Court opinions in *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed. 2d 147 (1973), and *Doe v. Bolton*, 410 U.S. 179, 93 S.Ct. 739, 35 L.Ed. 2d 201 (1973)." On December 10, 1974 this Court certified the instant action to be a class action.

This matter came before the Court for final hearings on the merits from January 13, 1975 through January 17, 1975 and on March 10, 1975. Thereafter, we granted the motions of the Attorney General of Pennsylvania and of the Commonwealth of Pennsylvania to intervene as parties defendant.

Plaintiff Planned Parenthood Association of Southeastern Pennsylvania, Inc. is a voluntary, non-profit health and social service agency, incorporated by the state of Pennsylvania. Planned Parenthood, which has 200 affiliates in the United States and is a member of Planned Parenthood/World Population, is dedicated to providing contraceptive information and family planning service. Planned Parenthood through its various departments, including its medical staff, provides and desires to continue providing services and/or referral guidance with respect to contraception, sterilization or abortion; maintaining in each of these efforts the goal of freedom of choice concerning family size and birth control methods. Planned Parenthood is completing plans to build and operate an abortion clinic, but at the present time it does not perform abortions at any of its facilities.

Plaintiff Dr. John Franklin is a licensed medical doctor practicing in the state of Pennsylvania, board-certified in obstetrics and gynecology. Dr. Franklin is a member of the staff at Thomas Jefferson University Hospital, the medical director of plaintiff Planned Parenthood Association of Southeastern Pennsylvania, Inc., the medical director of Booth Memorial Hospital of the Salvation Army, and a member of the intervening plaintiff Obstetrical Society of Philadelphia. In his capacity as medical director of Planned Parenthood, he supervises the operation of its clinic which provides family planning services, including birth control, pregnancy testing, pregnancy counselling and referral. In the calendar year 1974, Dr. Franklin performed 21 abortions through November 20th; and in the calendar year 1973, he performed 24 abortions. In 1971 and 1972, Dr. Franklin was the medical director of Philadelphia Family Planning, Inc., where he did approximately 10 to 12 abortion procedures a week for one year.

Plaintiff Concern for Health Options: Information, Care and Education, Inc. (CHOICE) is a non-profit corporation organized under the laws of the Commonwealth of Pennsylvania in 1974. CHOICE provides counselling and referral for pregnant women; and over 1,000 women have been seen at eight centers in and around Philadelphia. In

addition to its counselling and referral program, CHOICE performs ongoing evaluation of the services available to pregnant women, especially medical services. CHOICE publishes a "Resource and News Bulletin" which is distributed to its counsellors, all social service agencies which assist women with problem pregnancies, and other interested persons.

Plaintiff Clergy Consultation Service of Northeast Pennsylvania is a voluntary organization of clergy and women, who provide free counselling and referral for pregnant women. Clergy Consultation Service counsellors assist approximately 50 women per month, at three sites located in Scranton, Wilkes-Barre and Hazleton. Most of these counselled women are medically indigent, most are under 21 years of age, and most of them are single.

Intervening plaintiff Obstetrical Society of Philadelphia is a voluntary professional association of board-certified obstetricians and gynecologists; formed more than one hundred years ago to represent and protect the professional interests of members of these medical specialties in the Philadelphia area. The Society has over four hundred members who practice obstetrics and gynecology in the Greater Delaware Valley, including Philadelphia, eastern Pennsylvania, Delaware and southern New Jersey.

Defendant F. Emmett Fitzpatrick, Jr., is the District Attorney of Philadelphia County, and he is sued in his official capacity. In his official capacity defendant Fitzpatrick is responsible for the enforcement in Philadelphia of the laws of the Commonwealth of Pennsylvania, including the Abortion Control Act.

Defendant Frank S. Beal is the Secretary of Welfare of the Commonwealth of Pennsylvania, and he is sued in

his official capacity. In his official capacity defendant Beal is responsible for the conduct of the Commonwealth's Medical Assistance program, including implementing the restrictions imposed upon that program by the Abortion Control Act.

Intervening defendant Robert P. Kane is the Attorney General of the Commonwealth of Pennsylvania, and he is sued in his official capacity. In his official capacity intervening defendant Kane is the legal advisor of the Governor and the chief law officer of the Commonwealth.

For the reasons hereinafter stated, this Court holds that the following challenged sections of the Abortion Control Act and the related criminal sanctions are unconstitutional: the definition of "viable" found in Section 2; the spousal consent requirement found in Section 3(b) (i); the parental consent requirement found in Section 3(b) (ii); the determination of viability requirement found in Section 5(a); the performance of an abortion requirements found in Section 6(b); part of the reporting requirements found in Section 6(d); the prohibition of advertising requirement found in Section 6(f); and finally, the subsidizing of an abortion requirement found in Section 7. And for the reasons hereinafter stated, we hold that the following challenged sections of the Act and the related criminal sanctions are constitutional: the definition of "informed consent" found in Section 2; the informed consent requirement found in Section 3(a); the disposition of dead fetuses requirement found in Section 5(c); the determination of pregnancy requirment found in Section (6a); the facility approval requirement found in Section 6(c); part of the reporting requirements found in Section 6(d); and finally, the Health Department regulation requirements found in Section 8.

I. Justiciability

The threshold question for consideration is the justiciability of the instant litigation. The state challenges plaintiff's standing to contest the validity of the challenged statute in this case which lacks, as a party, a pregnant woman who has been denied an abortion. Initially the state contends that the plaintiff-physicians have no standing to bring this action. Standing, of course, entails

> . . . such a personal stake in the outcome of the controversy as to assure that concrete adverseness which sharpens the presentation of issues upon which the court so largely depends for illumination of difficult constitutional questions. *Baker v. Carr,* 369 U.S. 186, at 204, 82 S.Ct. 691, at 703, 7 L.Ed. 2d 663 (1962).

The state defendants appear to have overlooked the Supreme Court's treatment of a physician's standing in *Roe,* wherein the Court stated at 410 U.S. 188, 93 S.Ct. 745:

> We conclude, however, that the physician-appellants, who are Georgia-licensed doctors consulted by pregnant women, also present a justiciable controversy and do have standing despite the fact that the record does not disclose that any one of them has been prosecuted, or threatened with prosecution, for violation of the State's abortion statutes. The physician is the one against whom these criminal statutes directly operate in the event he procures an abortion that does not meet the statutory exceptions and conditions. The physician-appellants, therefore, assert a sufficiently direct threat of personal detriment. They should not be required to await and undergo a criminal prosecution as the sole means of seeking relief. [Citations omitted.]

We hold that the plaintiff-physicians in the case, *sub judice,* are not required to risk becoming defendants in criminal prosecutions since they have standing under the rationale of *Roe.*

We have previously determined that the physician plaintiffs may maintain this action on behalf of themselves and "the class of Pennsylvania physicians who perform abortions and/or counsel their female patients with regard to family planning and pregnancy including the option of abortion, and the sub-class of members of the Obstetrical Society of Philadelphia who practice in Pennsylvania." The evidence establishes that the physicians included in the class have patients who are married and desire abortions without spousal consent, patients who are minors and seek abortions without parental consent and patients who are indigent and must rely on Medical Assistance for payment of the costs of abortions[3]. Accordingly, we consider the instant action to be maintained on behalf of the class physicians and their patients in these three categories.

The state also contends that the plaintiff-referral agencies (i.e. Planned Parenthood Association of Southeastern Pennsylvania; Concern for Health Options: Information, Care and Education, Inc.; and Clergy Consultation Service of Northeastern Pennsylvania) have no standing to bring this action. Few would dispute that a referral agency actually threatened with prosecution as a counselor-conspirator or accessory in violation of the Abortion Con-

[3] See testimony of Drs. Franklin, Gerstley, Osofsky, Klaven and Matthews.

trol Act would have standing to seek a declaratory judgment of the constitutionality of the statute. Cf., *Doe, supra,* 410 U.S. at 189, 93 S.Ct. at 746. However, absent such threatened prosecution, it is more difficult to find that these plaintiffs do have standing. "The sole issue is whether there is a logical link between the status they assert . . . and the claim they seek adjudicated, or between their status and both the type of enactment attacked and the nature of the constitutional infringement alleged." *Doe v. Bolton,* 319 F.Supp. 1048, at 1052 (N.D. Ga. 1970). As referral agencies, plaintiffs attack a criminal statute potentially applicable to them that would subject them to significant criminal penalties; accordingly, we hold they have standing.

Standing is one aspect of justiciability. However, Article III of the United States Constitution limits the jurisdiction of the federal courts to "cases and controversies". It is well established that in actions for declaratory judgments, there must be "exigent adversity"; i.e., an actual controversy in which the constitutionality of the statute is drawn into question in a truly adversary context. See, e.g., *Golden v. Zwickler,* 394 U.S. 103, 89 S.Ct. 956, 22 L.Ed. 2d 113 (1969).

Looking at the evidence of record presently before us, it is clear that the physicians, both individually and as a class, have established a concrete adverseness; for they are the ones whom the Abortion Control Act would *directly* penalize. However, the plaintiff-referral agencies have presented no evidence to support their contention that they may be prosecuted as counsel-conspirators or accessories, and this Court finds, after reading the Act and noting the barren state of the record, that such a conclusion could only

be reached as a matter of pure speculation or conjecture on our part. Consequently, we hold that the claims of the plaintiff-physicians in this case present a justiciable controversy, while the claims of the plaintiff-referral agencies do not. Accordingly, we dismiss as to the referral agencies.

II. Analysis of Roe and Doe

The landmark decisions in the abortion area, which of necessity we must follow in a resolution of the case presently before us, are *Roe v. Wade, supra,* and *Doe v. Bolton, supra.*

Accordingly, we apply the mandate of the Supreme Court to the legislation presently before us. Part of that mandate appears at the end of the opinion in *Roe, supra,* 410 U.S. at 164-66, 93 S.Ct. at 732-33, where Mr. Justice Blackmun stated:

> To summarize and to repeat:
>
> 1. A state criminal abortion statute of the current Texas type, that excepts from criminality only a *life-saving* procedure on behalf of the mother, without regard to pregnancy stage and without recognition of the other interests involved, is violative of the Due Process Clause of the Fourteenth Amendment.
>
> (a) For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.
>
> (b) For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the healh of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.

(c) For the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.

2. The State may define the term "physician", as it has been employed in the preceding paragraphs of this Part XI of this opinion, to mean only a physician currently licensed by the State, and may proscribe any abortion by a person who is not a physician as so defined.

In *Doe v. Bolton*, 410 U.S. 179, 93 S.Ct. 739, 35 L.Ed. 2d 201, procedural requirements contained in one of the modern abortion statutes are considered. That opinion and this one, of course, are to be read together. . . .

[This] decision leaves the State free to place increasing restrictions on abortion as the period of pregnancy lengthens, so long as those restrictions are tailored to the recognized state interests. The decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician. If an individual practitioner abuses the privilege of exercising proper medical judgment, the usual remedies, judicial and intraprofessional, are available.

The language of the *Roe* decision clearly indicates that the Supreme Court reached its decision by making the following determinations: 1) there is a fundamental right to privacy; 2) this right encompasses the pregnant woman's decision to have an abortion; 3) being a fundamental right, the right to an abortion can be limited only by a compelling state interest; 4) the state has a compelling interest in the mother's health which arises approximately at the end of the first trimester of pregnancy; and 5) the state has a compelling interest in the life of the fetus when it become viable.

As the Supreme Court stated in its *Roe* decision, *Roe* should be read in conjunction with *Doe v. Bolton.* Thus in *Doe* the Court invalidated in part a more modern Georgia abortion statute because: 1) with respect to certain statutorily imposed requirements, the challenged statute failed to exclude the first trimester of pregnancy; 2) with respect to certain other statutorily imposed requirements, the state failed to prove that the statutory restriction was rationally connected to the objective the state sought to accomplish; and 3) with respect to other provisions, the statutorily imposed overview caused the abortion procedure to be regulated more strictly than any other medical or surgical procedure.

III. Burden of Proof

One overall issue that pervades this entire case, and which the parties have continually raised, is the question of burden of proof. The Supreme Court's decision in *Roe* clearly states that the pregnant woman's decision to have an abortion is a fundamental right which may be limited only at certain compelling points by legitimate state inter-

ests. In this regard, Mr. Justice Blackmun stated in *Roe, supra,* 410 U.S. at 155, 93 S.Ct. at 728:

> Where certain "fundamental rights" are involved, . . . regulation[s] limiting these rights may be justified only by a "compelling state interest," . . . and . . . [these] legislative enactments must be narrowly drawn to express only the legitimate state interests at stake. . . . [Citations omitted.]

We hold that the burden is on the defendants to show: 1) that there exists a legitimate state interest requiring a legislative enactment, 2) the point at which this legitimate state interest becomes compelling, and 3) that the legislative enactment is narrowly drawn to express only the legitimate state interest in question.

IV. Severability

Plaintiffs contend that the Abortion Control Act "is unconstitutional on its face and in its entirety on the ground that the legislative intent to unconstitutionally limit, deter, and regulate the abortion decision which is expressed in its title, language, and various provisions, vitiates the statute as a whole." Defendants argue: 1) the Act is constitutional, or in the alternative, 2) if any section is unconstitutional the statute's severability clause evidences an express legislative intent that this Court must heed[4]. Clearly

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[4]The relevant provision is as follows:

Section 9. Severability.—

If any provision of this act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

the effect of the sections herein declared unconstitutional is to improperly restrict the exercise of the fundamental right of the pregnant woman, in consultation with her physician, to make the abortion decision at points in time when the state has not demonstrated a compelling interest justifying statutory regulation. We have examined each section of the Act and we have determined, notwithstanding the fact that a number of sections are unconstitutional, that the invalid sections are severable and the Act is not unconstitutional in its entirety. Therefore, we now turn to a section-by-section examination of the Act.

V. Consent to Abortion

Spousal and Parental Consent

Plaintiffs contend "the parental and spousal consent provisions of the Act and the criminal provision associated therewith are unconstitutional and invalid infringements of their rights to privacy. . . ." Defendant Fitzpatrick concedes that Sections 3(b)(i), 3(b)(ii), and 3(e) to the extent that it relates to 3(b), are unconstitutional. However, the state defendants contend the parental and spousal consent provisions are constitutional and evidence the state's legitimate interest in protecting "the long-established inherent rights of spouses and parents concerning the familial unit and child welfare." The challenged provisions are as follows:

> Section 3. Consent to Abortion: Limitations on Public Officials.—
>
> . . . .
>
> (b) No abortion shall be performed upon any person in the absence of the written consent of (i) the spouse of such person provided that the whereabouts

of such spouse can be learned from such person or from other readily available sources and he can be notified and that the abortion is not certified by a licensed physician to be necessary in order to preserve the life or health of the mother, (ii) one parent or person in loco parentis of such person if such person is under eighteen years of age and unmarried unless the abortion is certified by a licensed physician as necessary in order to preserve the life of the mother.

. . . .

(e) whoever performs an abortion and without consent as required in subsections (a) and (b) of this section shall be guilty of a misdemeanor of the first degree. . . .

We find the spousal consent provision of the Act an unconstitutional infringement of a pregnant woman's fundamental right of privacy. Initially, we note that the Supreme Court did not rule directly upon the issues of spousal or parental consent in either *Roe* or *Doe*. Thus in *Roe, supra*, 410 U.S. at 165, 93 S.Ct. at 733, the Court states in a footnote:

> Neither in this opinion nor in *Doe v. Bolton*, 410 U.S. 179, 93 S.Ct. 739, 35 L.Ed. 2d 201, do we discuss the father's rights, if any exist in the consitutional context, in the abortion decision. No paternal right has been asserted in either of the cases, and the Texas and the Georgia statutes on their face take no cognizance of the father. We are aware that some statutes recognize the father under certain circumstances. North Carolina, for example, N.C. Gen. Stat. §14-45.1 (Supp. 1971), requires written permission for

> the abortion from the husband when the woman is a married minor, that is, when she is less than 18 years of age, 41 N.C.A.G. 489 (1971); if the woman is an unmarried minor, written permission from the parents is required. We need not now decide whether provisions of this kind are constitutional.

Though *Roe* and *Doe* do not directly decide the issues of spousal and parental consent, this Court concludes that of necessity these decisions by implication provide the backdrop against which these interests must be viewed. The Supreme Court's analysis in *Roe* clearly states that a woman has a qualified, though not absolute, right to decide to have an abortion. The woman's decision is qualified to the extent that there must be a balancing of her fundamental right of privacy with other important and legitimate interests at specified compelling points. Thus, in *Roe, supra*, 410 U.S. at 162-63, 93 S.Ct. at 731, the Court states:

> In view of all this, we do not agree that, by adopting one theory of life, Texas may override the rights of the pregnant woman that are at stake. We repeat, however, that the State does have an important and legitimate interest in preserving and protecting the health of the pregnant woman, whether she be a resident of the State or a nonresident who seeks medical consultation and treatment there, and that it has still another important and legitimate interest in protecting the potentiality of human life. These interests are separate and distinct. Each grows in substantiality as the woman approaches term and, at a point during pregnancy, each becomes "compelling."

It is imperative, therefore, that any state regulation in the field of abortion both take cognizance of the woman's fun-

damental right and draw the proper balance between a legitimate state interest and the pregnant woman's interest. The challenged spousal consent provision of the Abortion Control Act is invalid because it does not balance the interest of the pregnant woman with the purported interest, if there is a constitutional one, of the the husband; but rather the provision gives the spouse an unqualified and unconditional veto over the wife's decision to have an abortion, thus completely ignoring the fundamental right of the pragnant woman to make the abortion decision.

A number of other courts have come to the same conclusion and have invalidated statutorily imposed spousal consent provisions. Cf., *Doe v. Doe,* Mass. , 314 N.E. 2d 128 (1974); *Jones v. Smith,* 278 So. 2d 339 (Fla. Ct. App. 1973), *cert. den.,* 94 S.Ct. 1486 (1974); *Coe v. Gerstein,* 376 F.Supp. 695 (S.D. Fla. 1973), *app. dism.* and *cert. den.,* 94 S.Ct. 2246 (1974); *Doe v. Rampton,* 366 F.Supp. 189 (C.D. Utah 1973); *Doe v. Bellin Memorial Hospital,* 479 F.2d 756 (7th Cir. 1973); also see annotation at 62 ALR 3d 1097. We are aware of only one case wherein a spousal consent provision has not been invalidated, however, the Supreme Court has stayed enforcement of that particular statute. See *Planned Parenthood of Central Missouri v. Danforth,* 392 F.Supp. 1362 (E.D. Mo. 1975), *stay grta.,* 95 S.Ct. 1111 (1975).

The spousal consent provision of the Act mandates that a pregnant woman's spouse take the affirmative step of giving his consent before an abortion may be performed. We find this provision, requiring affirmative action, is not narrowly tailored to meet a legitimate interest of either the spouse or the state. Even if this Court were to find that the asserted interests of the husband were protected by the

Constitution, we would still have to take cognizance of the Supreme Court's pronouncement in *Roe,* that the husband's pregnant spouse has a fundamental right to decide to have an abortion, which prior to the second trimester must be "free of interference by the State." *Roe, supra,* 410 U.S. at 164, 93 S.Ct. at 732. We need not decide here whether the husband's interest in the abortion decision is in fact protected by the Constitution. The Supreme Court has determined that the wife's interest in the abortion decision is a fundamental right. Nevertheless, the statute before us requires, in every case, that the wife obtain the consent of her spouse for an abortion; consent is required even if the spouse asserts no interest in the wife or the family, or no paternal interest in the potential child. At least one of the state defendants' witnesses has testified that though it is oft times beneficial for the marital relationship for the husband to be informed and consulted with respect to the abortion decision, nevertheless, he should not be given absolute veto power over the wife's decision[5]. State restrictions on fundamental rights must be narrowly drawn to conform to the legitimate interests to be furthered. *Roe, supra,* 410 U.S. at 155, 93 S.Ct. at 728. Clearly the spousal consent provision of the Act is not narrowly drawn and cannot stand; we declare Sections 3(b) (i) and 3(e) to be unconstitutional.

We also find that the parental consent provision of the Act is an unconstitutional infringement of a minor woman's fundamental right of privacy in violation of the Fourteenth Amendment of the Constitution. We note that other courts have invalidated statutorily imposed parental consent provisions also. Cf., *Foe v. Vanderhoof,* 389

[5]See testimony of Amitai Etzioni.

F.Supp. 947 (D. Colo. 1975); *Baird v. Bellotti*, 393 F. Supp. 847 (D. Mass. 1975); *Coe v. Gerstein*, 376 F.Supp. 695 (S.D. Fla. 1973), *app. dism.* and *cert. den.*, 94 S.Ct. 2246 (1974); *Doe v. Rampton*, 366 F.Supp. 189 (C.D. Utah 1973); *Wolfe v. Schroering*, 388 F.Supp. 631 (W.D. Ky. 1974). Again, we are aware of only one case wherein a parental consent provision has not been invalidated; however the Supreme Court has stayed enforcement of that particular statute. See, *Planned Parenthood of Central Missouri v. Danforth*, 392 F.Supp. 1362 (E.D. Mo. 1975), *stay grtd.*, 95 S.Ct. 1111 (1975).

Initially, we agree with the analysis of the Washington Supreme Court in *State v. Koome*, 84 Wash. 2d 901 530 P.2d 260 (En Banc, 1975), where the Court states at 530 P.2d 263:

> Prima facie, the constitutional rights of minors, including the right of privacy, are coextensive with those of adults. Where minors' rights have been held subject to curtailment by the state in excess of that permissible in the case of adults it has been because some peculiar state interest existed in the regulation and protection of children, not because the rights themselves are of some inferior kind. . . . In some other cases minors' rights have been differentiated from those of adults because of a fundamental difference in the nature of the particular state interaction with juveniles.
>
> ....
>
> Several courts have upheld minors' privacy rights where no such special context or state interest existed. . . . Recognition of the equal status of the rights of minors seems particularly necessary with regard to the privacy rights involved here. . . . [Citations omitted.]

The state defendants argue, however, that the statute's abridgement of fundamental rights is justified by a compelling state interest not asserted in *Roe* and *Doe*. This interest is alleged to be a legitimate state interest in "safeguarding the societal role of parents in the supervision of their unemancipated minor children" and "preserving the family unit."

We agree that, whenever possible, parents should be involved in the medical decisions of unemancipated minor children. However desirable it may be to have parents involved in the abortion decision, it is clear that the state may not destroy the fundamental right of the pregnant minor to make the final decision concerning abortion, provided that she is capable of making an intelligent, informed decision. The Abortion Control Act is not an attempt to encourage parental involvement, rather it destroys the right of the minor to make the abortion decision, without regard for her age, maturity, intelligence or ability to make an informed decision. It is significant that the state defendants' own witnesses do not support the state's view that parents must invariably be involved in the decision of the pregnant minor; for when serving as counselors, defendants' witnesses do not involve the parents without the voluntary permission of the minor[6].

State defendants contend that "although both adults and minors are protected by the Fourteenth Amendment, the state may impose more stringent regulations on the activities of children than it may adopt with respect to

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[6]See testimony of Michael Bradley, Erma Craven and Margaret O'Neill.

adults." In support of this proposition defendants cite to the Court the cases of *Wisconsin v. Yoder*, 406 U.S. 205, 92 S.Ct. 1526, 32 L.Ed. 2d 15 (1972); *Ginsburg v. New York*, 390 U.S. 629, 88 S.Ct. 1274, 20 L.Ed. 2d 195 (1968); and *Prince v. Massachusetts*, 321 U.S. 158, 64 S.Ct. 438, 88 L.Ed. 645 (1944). The cases relied on by defendants arise from a factual situation where there was a conflict between the parent and the state as to what was in the best interest of the child. In the instant case, however, we are faced with a clearly distinguishable factual situation where there is merely a potential conflict between the parent and the child as to what is in the best interest of the child. Where there is such a potential conflict between the interests of the child and other possible interests of the parent, the state cannot statutorily mandate that the parent must always prevail, for parental consent may not simply be unilaterally substituted for consent of the child, particularly, where as here, the fundamental right is infringed without affording the child any rights of due process.

Even if we were to agree with state defendants' proposition that the expression of protected rights asserted on behalf of minors may be curtailed or even prohibited, Section 3 (b) (ii) of the Act still could not stand. We note that the state of Pennsylvania enacted the Act of February 13, 1970, P.L. , No. 10, §§1-5[7] entitled "Minors' Consent to Medical, Dental and Health Services." The relevant sections of said Act are as follows:

§10101. Individual consent

Any minor who is eighteen years of age or older, or has graduated from high school, or has married, or

[7] 35 P.S. §10101-10105.

has been pregnant, may give effective consent to medical, dental and health services for himself or herself, and the consent of no other person shall be necessary.

. . . .

§10103. Pregnancy, venereal disease and other reportable diseases

Any minor may give effective consent for medical and health services to determine the presence of or to treat pregnancy, and venereal disease and other diseases reportable under the act of April 23, 1956 (P.L. 1510), known as the "Disease Prevention and Control Law of 1955," *and the consent of no other person shall be necessary.* [Emphasis added.]

Thus, at present a pregnant minor who chooses to give birth may receive all necessary medical treatment without the consent of her parents, as a matter of Pennsylvania statutory law. Yet Section 3 (b) (ii) of the Act would require a pregnant minor who chooses to abort to obtain parental consent before she could receive medical treatment to terminate the pregnancy. Such a distinction is clearly inconsistent with *Roe* and *Doe* because this section of the Act singles out the abortion procedure as it applies to minors and places an extra layer of restrictions upon the effectuation of a minor's fundamental right to choose to have an abortion.

Furthermore, the parental consent provision before us is not narrowly tailored to meet the alleged state interest in protecting the parents role in supervising their unemancipated minor children. As the Court in *State v. Koome, supra*, 530 P.2d at 265, recently observed in striking down a similar provision:

> In the circumstances envisioned by this statute there seems to be little parental control left for the State to help salvage. An unmarried minor has become pregnant, and her determination to get an abortion is unalterably opposed by her parents. Reestablishment of parental control by resort to the pure force of the criminal law seems both futile and manifestly unwise in such a situation. . . .

Finally, the asserted state interest in ensuring that the minor's decision be informed does not justify the parental consent provision of the Act. Under the terms of the Act, parental consent is mandated under every circumstance except where "necessary in order to preserve the life of the mother." Thus, a minor must obtain parental consent even if carrying to term endangers her health. The provision here in question is overbroad for it provides an absolute parental veto where less restrictive means are available to ensure that the minor's decision is a "knowing and intelligent" one.[8]

Accordingly, for the reasons stated above, we declare Sections 3(b) (ii) and 3(e) to be inconsistent with the Supreme Court's decisions in *Roe* and *Doe*, and therefore unconstitutional.

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[8]The physician-patient consultation that should precede any abortion provides information, advice as to alternatives, and time for deliberation. Moreover, Pennsylvania common law requires that physicians determine that a minor's decision to consent to any form of medical care is both adequately informed and considered; civil liability is available to enforce this requirement. See, e.g., Dunham v. Wright, 423 F.2d 940 (3d Cir. 1970) and cases cited therein.

VI. Protection of Life of Fetus

A. Viability and Potential Viability

Viability as defined in Section 2 and made operative by the Act, with criminal sanctions provided, is challenged by the plaintiffs as being unconstitutionally vague and overbroad in that as it is used in Section 5 it infringes the fundamental right of the pregnant woman to decide in consultation with her physician to have an abortion, without concern for potential fetal life, at any time prior to the 24th week of gestation. However, defendants contend that since the Act leaves the determination of viability to the physician's best medical judgment, it comports with the prevailing constitutional standards of *Roe* and *Doe* and embodies the state's important interest in protecting the life of the fetus. The challenged sections are as follows:

> Section 2. Definitions.—As used in this act.
> . . . .
>
> "Viable" means the capability of a fetus to live outside the mother's womb albeit with artificial aid.
>
> Section 5. Protection of Life of Fetus.—
>
> (a) Every person who performs or induces an abortion shall prior thereto have made a determination based on his experience, judgment or professional competence that the fetus is not viable, and if the determination is that the fetus may be viable, shall exercise that degree of professional skill, care and diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted and the abortion

technique employed shall be that which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother.

. . . .

(d) Any person who fails to make the determination provided for in subsection (a) of this section, or who fails to exercise the degree of professional skill, care and diligence or to provide the abortion technique as provided for in subsection (a) of this section, . . . shall be subject to such civil or criminal liability as would pertain to him had the fetus been a child who was intended to be born and not aborted.

The Act defines viability as "the capability of a fetus to live outside the mother's womb albeit with artificial aid." Plaintiffs contend there is a difference of opinion among physicians as to the period of gestation indicated by the statutory definition in question. Defendants contend that in *Roe*, the Supreme Court recognized that viability occurred when the fetus was "potentially able to live outside the mother's womb, albeit with artificial aid." *Roe, supra*, 410 U.S. at 160, 93 S.Ct. at 730. Thus defendants argue that a definition in keeping with the aforementioned pronouncement of the Supreme Court cannot be considered vague. The issue then is whether or not the Supreme Court intended to limit its holding concerning viability to the quoted language urged by defendants; for we note the Court stated in the very next sentence: "Viability is usually placed at about 7 months (28 weeks) but may occur earlier, even at 24 weeks." *Roe, supra*, 410 U.S. at 160, 93 S.Ct. at 730.

Defendants also argue that there is a "common medical consensus as to the meaning of the term 'viability' and the methods uniformly used by the medical community in determining such." We note that testimony of witnesses, affidavits and depositions were offered by both parties on this issue. We believe that a preponderance of the evidence supports a finding that there is not a consensus within the medical community as to the gestational age at which viability occurs. Moreover, viability as defined in the Act, without reference to gestational age, is confusing even to members of the medical profession. The testimony of record does not indicate a consensus within the medical community as to the meaning of viability as defined by the Act; but rather there is only a consensus as to the method for determining gestational age. Thus, the physicians who testified agreed that gestational age was determined by the physician using his best judgment in correlating the menstrual history of the particular pregnant woman with his findings from a physical examination of the pregnant woman. It is clear from the evidence that while not every physician would reach exactly the same determination as to gestational age, there would be a consensus within reasonable and tolerable limits.

The ability of a fetus to live outside the mother's womb cannot be determined directly. To reach such a judgment physicians must correlate certain probability of survival factors with the gestational age to determine viability as defined by the Act. The evidence clearly demonstrates that the statistical data available to the physician concerning fetus survival is not precise; also other variables such as the mother's health and the quality of hospital facilities in the community must be taken into consider-

ation. There is a lack of consensus within the medical community as to "the capability of a fetus to live outside the mother's womb albeit with artificial aid" when the gestational age of the fetus is determined to be between 20 and 28 weeks. The closer gestational age is to 20 weeks, the greater is the probability that the fetus cannot live outside the mother's womb; the closer gestational age is to 28 weeks, the greater is the probability that the fetus can live outside the mother's womb. The inability of physicians to agree in this area is demonstrated by the fact that Dr. Franklin, a plaintiff, believed that the statistical probabilities dictated a finding that viability would only occur at approximately 28 weeks, based upon a 10 percent probability of survival rate for fetuses of 28 weeks gestation. Dr. Gerstley, who also appeared on behalf of plaintiffs, did not completely agree with Dr. Franklin's analysis and set 24 weeks as the minimum period necessary for viability. Similarly, physicians presented on behalf of defendants did not agree among themselves nor with the plaintiffs' physicians. Thus Dr. Keenan placed viability at 26 weeks, based upon a 10 to 30 percent probability of survival rate for fetuses of 26 weeks gestation. A fair reading of the testimony of another physician called by the defendants, Dr. Mecklenburg, demonstrates that he would reach the conclusion that viability occurred at 20 weeks gestation[9].

[9]The specific testimony of Dr. Mecklenburg concerning this issue was as follows:

Mr. Morris: Doctor, as one who performs abortions I want to read you a sentence and ask you what it means to you. The sentence is, "Viability means capability of a fetus to live outside the woman's womb albeit with artificial aid" . . . .

Dr. Mecklenburg: I would agree with that definition of viability. I think that it has been current. I think it is a definition that takes into account medical progress, the fact that it is constantly changing. My perusal of the medical literature would lead me to believe that potential or continued life exists as early as 20 weeks—not in the current edition of Eastman's Obstetrics Book, but in the previous edition, the earliest report a survivor was reported as a delivery at 20 weeks gestation. In my own experience I have—the earliest survival that I have had is a patient who was 21 weeks from the time of conception or 23 weeks from the first day of her last menstrual period. The child is a year and a half old and normal. (Tr. 1/14/75, pp. 82-3.)

Defendants argue at page 38 of their post-trial brief that viability can only be said to exist with absolute certainty at 26 to 28 weeks gestation and the Abortion Control Act does not prohibit an abortion prior thereto. Of course, this is counsel's interpretation of the statute and not the language of the statute. Indeed, if the statute had even limited viability to 24 weeks gestation, it would be in conformity with the pronouncement of *Roe*, and not subject to a successful challenge. Nevertheless, we must decide the issue before us on the basis of the statute as written, rather than as interpreted by counsel.

In considering the facial validity of the challenged definition of viability of the Abortion Control Act, and Section 5 as it incorporates the definition, we are guided by the analysis of Mr. Justice Marshall found in *Grayned v. City of Rockford*, 408 U.S. 104, at 108-9, 92 S.Ct. 2294, at 2298-9, 33 L.Ed. 2d 222 (1972):

> It is a basic principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined. Vague laws offend several important values. First, because we assume that man is

free to steer between lawful and unlawful conduct, we insist that laws give the person of ordinary intelligence a reasonable opportunity to know what is prohibited so that he may act accordingly. Vague laws may trap the innocent by not providing fair warning. Second, if arbitrary and discriminatory enforcement is to be prevented, laws must provide explicit standards for those who apply them. A vague law impermissibly delegates basic policy matters to policemen, judges, and juries for resolution on an *ad hoc* and subjective basis, with the attendant dangers of arbitrary and discriminatory application. Third, but related, where a vague statute "abut[s] upon sensitive areas of basic first amendment freedoms," it "operates to inhibit the exercise of [those] freedoms." Uncertain meanings inevitably lead citizens to "'steer far wider of the lawful zone' . . . than if the boundaries of the forbidden areas were clearly marked." [Footnotes omitted.]

We find that the Abortion Control Act's definition of viable is vague because it does not notify physicians as to what conduct on their part is prohibited. We have carefully considered the arguments of defendant and particularly the contention that while the legislature could have defined the standard for prohibited conduct in terms of gestational age, it was entitled to define it as set forth in the Act, especially where the definition in the Act will continue to be valid even when advances in the medical profession lower the gestational age for viability. Of course, the very flexibility argued for by defendants contributes to the vagueness of the Act. Moreover, the Act may reasonably be interpreted in the medical community as setting viability

at a substantially lower gestational age than the 26 to 28 weeks which defendants' counsel contends it presently sets.

Plaintiffs also argue that the vagueness of the definition of viability subjects them to possible arbitrary and discriminatory prosecution. The evil is one recognized by Justice Marshall in *Grayned v. City of Rockford, supra,* where he states at 408 U.S. 108-9, 92 S.Ct. 2299: "A vague law impermissibly delegates basic policy matters to policemen, judges, and juries for resolution on an *ad hoc* and subjective basis, with the attendant dangers of arbitrary and discriminatory application." We believe that such a danger exists here for, without an objective standard to guide law enforcement officers, prosecutors and courts, physicians will be subject to prosecution controlled only by the subjective determinations of those charged with law enforcement. The possibility of such arbitrary enforcement certainly will, as plaintiffs contend, inhibit and deter physicians from performing abortions after a fetus has reached the gestational age of 20 weeks. Such a limitation prior to the 24th week of gestation is inconsistent with the fundamental right of a pregnant woman to obtain an abortion without regard to the potential for fetal life within the second trimester of the pregnancy. We find that the Supreme Court in *Roe* intended to set the lowest limit at which viability may be deemed to occur at the 24 week period. Accordingly, we hold that Section 2's definition of viability, Section 5 (a) of the Act, which incorporates that definition, and Section 5 (d), which imposes civil and criminal sanctions, are inconsistent with *Roe,* and are therefore unconstitutional.

In addition to challenging the definition of viability as being vague, plaintiffs also challenge the right of the

legislature to regulate the procedure used where the fetus "may be viable", as evidenced by the language of Section 5(a) and enforced by Section 5(d) of the Act. *Roe* makes it abundantly clear that the compelling point at which a state in the interest of fetal life may regulate, or even prohibit, abortion is not before the 24th week of gestation of the fetus, at which point the Supreme Court recognized the fetus then presumably has the capability of meaningful life outside the mother's womb. Consequently, *Roe* recognizes only two periods concerning fetuses. The period prior to viability, when the state may not regulate in the interest of fetal life, and the period after viability, when it may prohibit altogether or regulate as it sees fit. The "may be viable" provision of Section 5(a) tends to carve out a third period of time of potential viability. Defendants' witness, Dr. Keenan, testified that based upon his interpretation of Act 209, the Act's definition of potential viability occurs at 20 to 26 weeks gestation. (See Tr. 1/17/75, p. 549.) It is clear that in carving out this new time period labeled "may be viable" the state is regulating abortions during the second trimester, when it may lawfully do so only in the interest of maternal health. Yet the state does not claim the provision to be in the interest of maternal health, nor has it shown any connection between this provision concerning fetuses which "may be viable" and maternal health. Clearly, the state seeks to justify this provision only as a measure in furtherance of its claimed interest in protecting potentially viable fetuses. Since this provision does not meet the requirements of *Roe*, we declare it to be unconstitutional.

In reaching our conclusion concerning the issue of viability as defined; and as incorporated in Section 5(a),

we have considered two cases which defendants have cited as upholding similar definitions of viability: *Wolfe v. Schroering*, 388 F.Supp. 631 (W.D. Ky. 1974) and *Planned Parenthood of Central Missouri v. Danforth*, 392 F.Supp. 1363 (E.D. Mo. 1974), *stay grtd.*, 95 S.Ct. 1111 (1974). After examining *Wolfe* and *Danforth* we are not persuaded by the reasoning of the three-judge courts in either case, but rather we are bound to follow the mandate of the United States Supreme Court in *Roe* and *Doe*. Our decision herein is consistent with the holdings of several other courts. See, for example, *Hodgson v. Anderson*, 378 F.Supp. 1008 (D. Minn 1974), *appeal dismissed*, 95 S.Ct. 819 (1975); and *Leigh v. Olson*, 385 F.Supp. 255 (D. N.D. 1974).

B. Disposition of Dead Fetuses

Plaintiffs attack Section 5(d) of the Act which requires the Department of Health to make regulations to provide for the humane disposition of dead fetuses. Plaintiffs contend that this provision is an overbroad unconstitutional invasion of the pregnant woman's right of privacy with respect to pregnancies terminated during the first and second trimesters, wherein the only compelling state interest relates to maternal health in the second trimester. Defendants respond to plaintiffs' attack with the argument that "the section in question in no way burdens the exercise of a constitutional right but instead expresses a clear state interest in public health and welfare." The challenged provision is as follows:

Section 5. Protection of Life of Fetus.—

. . . .

(c) The department shall make regulations to provide for the humane disposition of dead fetuses.

. . . .

Plaintiffs' challenge to this section is based on a fear that future adopted regulations will require elaborate funeral provisions, treating the fetus as a human, and that psychologically and financially such regulations will burden a pregnant woman's decision concerning abortion. At the time of trial, plaintiffs made it clear that they did not question the right of the Department of Health to make regulations concerning the disposition of live tissue. The following statement by counsel for the plaintiffs sets forth plaintiffs' position in this regard:

> As far as the department's ability to make regulations as to disposition of live tissue generally, or for that matter with respect to disposition of fetal tissue for purposes of laboratory studies and such, that's no problem, but that power already exists more than amply under the general powers of the Department of Health, which are extremely broad.
>
> So we are not, and there is no issue here of preserving a power which the Department of Health would not otherwise possess. (Tr. 1/15/75, p. 166.)

In addition the state, in its post-trial brief notes that the plaintiffs do not object

> to incineration of dead fetuses. Certainly, no argument is made regarding fears expressed by plaintiffs on burial requirements. The Commonwealth would submit that the reasonable intent of the Act is to preclude the mindless dumping of aborted fetuses on to garbage piles. . . . . [Thus,] the obvious public health considerations regarding sanitation, disease prevention and surgical standards more than amply justify the requirement of Section 5 (a).

We view the particular provision in question as being merely an enabling statute which is not unconstitutional on its face. We believe that the state in the constitutional exercise of its police power may provide for the disposition of dead fetuses to protect the public health. The language of the statute which troubles plaintiffs is that it requires the *humane* disposition of dead fetuses. Of course, a regulation that requires expensive burial may very well invade the privacy of the pregnant woman and burden her decision concerning an abortion. However, no such regulation has been adopted to date pursuant to Section 5 (c), and we find that this section is not unconstitutional on its face. We, of course, do not foreclose a future challenge to any unconstitutional regulation adopted pursuant to this section.

VII. Control of Practice of Abortion

A. Pregnancy Determination

Section 6 of the Act is concerned with the control of the practice of abortion. Plaintiffs challenge Section 6 (a), which is criminally enforced by Section 6 (i), to the extent that it requires a positive determination of pregnancy prior to the performing of an abortion. Defendants respond by arguing that the positive pregnancy determination requirement manifests a compelling state interest in maternal health. The challenged provision is as follows:

Section 6. Control of Practice of Abortion.—

(a) Every person who intends to perform or induce an abortion shall first have made a determination of the pregnancy of the person to be aborted.

. . . .

At page 52 of their post-trial brief, the plaintiffs concede ". . . physicians agree that it is desirable to have positive pregnancy indications prior to undertaking an abortion procedure on the grounds that, generally, individuals should not be subjected to medical procedures without a clear indication of the requirement therefore, . . ." However, notwithstanding this concession, plaintiffs argue that "under certain circumstances the procedure known as menstrual extraction can be, and desirably is, performed prior to the time when [an] average facility can determine with absolute certainty whether or not the patient is pregnant." Thus, plaintiffs only factual reason for challenging this section is that occasionally a patient may seek an abortion by menstrual extraction within the first few days of pregnancy, and at that time a reliable test for determining pregnancy is not available outside of Philadelphia County.[10]

There appears to be substantial agreement between the parties that a menstrual extraction is an abortion procedure and that there are possible risks to the health of the

[10]Plaintiffs agree with defendants that Planned Parenthood, in a program in cooperation with Jefferson Hospital of Philadelphia, can obtain a positive testing within the first few days of pregnancy by a radio immuno assay. Also, apparently there is no question that residents of surrounding counties in the Eastern District of Pennsylvania could also receive such testing through the facilities of Planned Parenthood or Jefferson Hospital.

female patient from infection and hemorrhage. An additional relevant factor in our determination in this area is the response of plaintiffs' witness, Dr. Matthews, to questions put to him by defense counsel on cross-examination:

Mr. Mansmann: Now, you had testified about a menstrual extraction, and you performed them at your clinic; is that right?

Dr. Matthews: Yes.

Mr. Mansmann: Is it your medical opinion that it would be better for a woman to see whether or not she is pregnant before she undergoes a menstrual extraction, or does it make any difference?

Dr. Matthews: I am not overjoyed with menstrual extraction as a procedure. Because if you do them within one week of the last missed period, probably only about 50 to 55 percent of them will be pregnant. (Tr. 1/14/75, p. 126.)

In sum, it is plaintiffs' contention that even though a prior determination of pregnancy is desirable before an abortion procedure is performed, Section 5 (a) of the Act is unconstitutional because it is not limited to the period following the first trimester of pregnancy, when the state may lawfully regulate abortions in the interest of maternal health. However, plaintiffs do concede that preventing non-pregnant women from undergoing abortion procedures is in the interest of female health.

We believe *Roe* mandates that once a pregnancy has been determined to exist, the state may not regulate in the interest of maternal health during the first trimester of pregnancy. Nevertheless, we do not believe that *Roe* precludes the state from requiring a positive determination of

pregnancy prior to the performance of an abortion procedure in furtherance of its interest in protecting nonpregnant females from undergoing unneeded abortion procedures. We do not believe that the Supreme Court intended by its *Roe* protection of pregnant females to preclude the statutory protection of nonpregnant females in the manner here challenged. Accordingly, we hold that Section 6 (a) is constitutional.

B. Performance of Abortion Subsequent to Viability

Plaintiffs challenge Section 6 (b) of the Act, which is criminally enforced by 6 (i), to the extent that it incorporates the definition of viability found in Section 2 of the Abortion Control Act. Defendants respond by arguing that the definition of viability is in accord with *Roe,* and embodies the state's interest in protecting the potential life of the fetus. The challenged provision is as follows:

> Section 6. Control of Practice of Abortion.—
>
> . . . .
>
> (b) No abortion shall be performed within the Commonwealth of Pennsylvania during the stage of pregnancy subsequent to viability of the fetus except where necessary, in the judgment of a licensed physician, to preserve the life or health of the mother.
>
> . . . .

Plaintiffs acknowledge the right of the state to prohibit abortions subsequent to viability but attack the definition of viability for the reasons hereinbefore set forth in our analysis of Section 2 and Section 5 of the Act. We have hereinbefore determined that the Act's definition of viability is unconstitutionally vague; accordingly, Section 6

(b), which incorporates that infirm definition, is declared to be unconstitutional.

C. Abortion Facility Approval

Plaintiffs challenge Section 6 (c), which is criminally enforced by Section 6 (i), to the extent that it requires an abortion to be performed in a facility approved by the Department of Health. Citing as authority the cases of *Nyberg v. City of Virginia,* 495 F.2d 1342, at 1345 (8 Cir. 1974); *Word v. Poelker,* 495 F.2d 1349 (8 Cir. 1970); and *Hodgson v. Anderson,* 378 F.Supp. 1008, at 1016 (D. Minn. June 27, 1974), plaintiffs contend that this provision is unconstitutional because no regulation of abortion may take place in the first trimester and the statute fails to take cognizance of the separate trimesters of pregnancy. Defendant Fitzpatrick concedes that Section 6 (c) is unconstitutional insofar as it requires facility approval with respect to first trimester abortions. However, the state defendants contend that the provision in question is constitutional because state regulation in this area is related to the state's legitimate interests in protecting maternal health and would not intrude on the abortion decision. The challenged provision is as follows:

> Section 6. Control of Practice of Abortion.—
>
> . . . .
>
> (c) No abortion shall be performed within the Commonwealth of Pennsylvania except by a licensed physician and in a facility approved to do so by the Department of Health in accordance with its rules and regulations.
>
> . . . .

We note that the Department of Health has not presently adopted any regulations pursuant to this provision of the Act. It is admitted by plaintiffs that the Pennsylvania Department of Health, after public hearings, issued regulations governing free standing abortion clinics prior to the enactment of the Act. It is further admitted that hospitals are facilities approved by the Department of Health and that the regulations adopted prior to the enactment of the Act do not instrude upon the decision of whether or not to abort, or the decision of how to abort. Finally, it is admitted that the present Health Department's regulations do not constitute an invasion into the physician-patient relationship and that these regulations do not intrude upon the woman's right of privacy. (See Tr. 1/17/75, pp. 521-522.) Thus, the question concerning the constitutionality of Section 6(c) is tendered to us with a clear record of regulation in the area by the Department of Health pursuant to its general powers. It is undisputed that no regulations have as yet been promulgated pursuant to Section 6(c) of the Act.

Plaintiffs succinctly state their position with respect to this provision in their post-trial brief at page 56 as follows:

> Plaintiffs do not challenge reasonable regulations of abortion promulgated under the general powers of the Department of Health, and we do not believe that the validity of the abortion regulations promulgated prior to the enactment of this statute is at issue here. However, we contend that the provisions of the present Act with regard to regulation of abortion should be struck down. To the extent that they reflect the legislative attempt to "conrol" abortion they are unconstitutional. To the extent that they merely purport to enable the Department to promulgate reasonable regulations to protect maternal health, they are not supported by any legitimate state purpose, since they are redundant of the Department's general powers.

From the record in this case and the statements of counsel in their post-trial brief, it is indeed open to question whether or not there is a real challenge by plaintiffs to this particular provision of the Act, and accordingly, whether there is a justiciable controversy presently before the Court in this regard. However, we consider plaintiffs' challenge to be that an act which authorizes the future adoption of regulations in this area is unconstitutional on its face, if it does not also provide that the regulations only apply to abortions performed after the first trimester. We do not believe that the provision in question is unconstitutional on its face, nor do we believe that it is inconsistent with either *Roe* or *Doe* in merely authorizing regulations. Of course, any regulations promulgated in the future must be consistent with the requirements of the Supreme Court.[11] Accordingly, we declare Section 6(c) not to be unconstitutional on its face and deny plaintiffs' request for injunctive relief.

D. Information to be Reported Concerning Abortions

Plaintiffs challenge Section 6(d) of the Act, which is criminally enforced by Section 6(i), to the extent that it requires information relating to whether the abortion was necessary to preserve the mother's life or health, and the

[11]For a more recent, post-Roe decision in this area, see Friendship Medical Center, Ltd. v. Chicago Board of Health, 505 F.2d 1141 (7th Cir. 1974), cert. den., 95 S.Ct. 1438 (1975).

spousal and parental consent provisions hereinbefore declared to be unconstitutional. These consent provisions are found in Section 3 of the Act. Defendant Fitzpatrick concedes that the spousal and parental consent provisions of the Act are unconstitutional; however, the state defendants contend that both the spousal and parental consent provisions and Section 6(d) of the Act are constitutional. The challenged provision is as follows:

> Section 6. Control of Practice of Abortion.—
>
> ....
>
> (d) Every facility in which an abortion is performed pursuant to this act within the Commonwealth of Pennsylvania shall currently make and keep on file upon forms prescribed by the Department of Health a verified statement signed by the person who performed the abortion setting forth the following information with respect to such abortion: . . . the name and address, if known, of the spouse of the woman; the name and address, if known, of the parent or person in loco parentis if the woman is under eighteen years of age and unmarried; the approximate age, in months of the fetus; a full statement of those facts upon which the person performing the abortion relied as establishing that the abortion was necessary to preserve the life or health of the mother. Affixed to such statement shall be a copy of each of the documents showing consent to abortion as required by section 3 of this act. . . .

Section 6(d) of the Act mandates the reporting of information which is directly related to Section 3(b)(i), 3(b)(ii), and 6(b). However, we have declared the requirements of spousal consent found in Section 3(b)(i) and parental consent found in Section 3(b)(ii), and the performance of abortion requirements found in Section 6(b), to be unconstitutional. Accordingly, we declare unconstitutional the reporting requirements of Section 6(d) that seek information as to:

> [T]he name and address, if known, of the spouse of the woman; the name and address, if known, of the parent or person in loco parentis if the woman is under eighteen years of age and unmarried; . . .; a full statement of those facts upon which the person performing the abortion relied as establishing that the abortion was necessary to preserve the life or health of the mother.

E. Prohibition Against Abortion Advertising

Plaintiffs challenge Section 6(f) of the Act, which is criminally enforced by Section 6(i), to the extent it deprives physicians of their rights to free speech, due process of law, and equal protection of the law. Defendants urge that the Act's "ban on abortion advertising narrowly prohibits commercial solicitation in the medical health field in accord with prevailing constitutional authority." The challenged provision is as follows:

> Section 6. Control of Practice of Abortion.—
>
> ....
>
> (f) No physician, clinic or other person or agency shall engage in solicitation or advertising having the purpose of inviting, inducing or attracting members of the public to come to such physician, or to purchase abortifacients.
>
> ....

Plaintiffs in their post-trial brief at page 54 contend, and we find, "the evidence in this case indicates that a class-plaintiff, Dr. Marshall Klavan, has subscribed to and desire[s] to publish yellow page advertising and to provide information to referral service agencies with the purpose of inducing members of the public to utilize the services of his clinic . . ."

Defendant Fitzpatrick argues that the plaintiffs "cannot complain of a statute which merely enacts the self-imposed limitation of the medical community." Nevertheless, defendant Fitzpatrick "would agree that yellow page listings would not constitute reprehensible advertisement so long as those listings comported substantively with the above mentioned standards." Thus, the position of defendant Fitzpatrick is that a yellow page listing, such as plaintiffs seek, does not violate the medical community's Canons of Ethics.

The state defendants, on the other hand, defend the solicitation or advertising ban of the Act even as to the dissemination of the information proposed by Dr. Klavan. Moreover, the state defendants deny that plaintiffs have standing to raise the First Amendment issue presently before us; and alternatively, argue that even if plaintiffs have standing, the relief requested, should be denied because "a clear line of constitutional authority exists in the First Amendment area recognizing the power of the government to regulate commercial advertising."

Subsequent to final hearing in this matter, the United States Supreme Court decided the case of *Bigelow v. Commonwealth of Virginia,* U.S. , 43 U.S.L.W. 4734 (June 16, 1975). Under the test set forth in *Bigelow,* it is clear that plaintiffs have asserted a legitimate First Amendment interest and have standing to challenge Section 6(f) of the Act as being facially overbroad. The Supreme Court stated in *Bigelow, supra,* 43 U.S.L.W. at 4736: "We give a defendant standing to challenge a statute on grounds that it is facially overbroad, regardless of whether his own conduct could be regulated by a more narrowly drawn statute, because of the 'danger of tolerating, in the area of First Amendment freedoms, the existence of a penal statute susceptible of sweeping and improper application'. *NAACP v. Button,* 371 U.S., at 433."

In *Bigelow,* Mr. Justice Blackmun in his opinion for the Court said: "The Court has stated that 'a State cannot foreclose the exercise of constitutional rights by mere labels'. *NAACP v. Button,* 371 U.S., at 429. Regardless of the particular label asserted by the State—whether it calls speech 'commercial' or 'commercial advertising' or 'solicitation'—a court may not escape the task of assessing the First Amendment interest at stake and weighing it against the public interest allegedly served by the regulation. . . ."

Thus, contrary to the state defendants' contention, merely applying a label "commercial solicitation" does not justify narrowing the protection of expression secured by the First Amendment; particularly where the activity advertised is not illegal, nor in violation of professional ethics, and, where as here, the activity advertised pertains to the constitutionally protected interests of pregnant women who may desire the information in the exercise of their fundamental right to decide to have an abortion.

In support of Section 6(f), the state defendants contend that the provision in question furthers the state's interest in protecting maternal health. Yet the state has failed

to prove in any rational manner how the satutory prohibition of the proffered information would promote its asserted interest in maternal health. Clearly the First Amendment interests at stake here outweigh the asserted interests of the state; accordingly, we declare Section 6 (f) to be unconstitutional.

F. Criminal Sanctions

Plaintiffs challenge Section 6 (i) of the Act to the extent it subjects physicians and others to criminal penalties for the violation of Sections 6 (a) to 6 (f). The challenged section is as follows:

> Section 6. Control of Practice Abortion.—
>
> . . . .
>
> (i) Any person or agency who violates any of the provisions of subsection (a), (b), (c) or (g) of this section is guilty of a misdemeanor of the first degree and any person or agency who violates any of the provisions of subsection (d), (e) or (f) of this section is guilty of a misdemeanor of the third degree.

In conformity with this Court's above determination that Sections 6 (b), 6 (d) in part, and 6 (f), are unconstitutional we declare that Section 6 (i) of Act 209 is unconstitutional to the extent that it ascribes criminal penalties for the violation of Section 6 (b), or the infirm portion of Section 6 (d), and 6 (f).

VIII. Subsidizing of Abortions

Section 7 of the Abortion Control Act is concerned with the subsidizing of abortions. Plaintiffs attack this section on the grounds that it: 1) "imposes an unconstitutional limitation upon the right of medically indigent

women to determine with their physician to terminate a pregnancy during the first two trimesters, 2) classifies women on the basis of wealth with regard to the medical standards for abortion, and 3) discriminates against medically indigent who choose abortion by failing to pay for their medical treatment while paying the full cost of the medical treatment of women who choose childbirth," allegedly in violation of Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., and the Equal Protection Clause of the Fourteenth Amendment. Defendant Fitzpatrick concedes the unconstitutionality of this section. However, the state defendants contend this provision is constitutional because: 1) the fundamental right to decide to terminate a pregnancy by abortion does not include a fundamental right that requires the state to pay for the abortion, and 2) in an effort to conserve limited state resources, the state has a legitimate interest in paying only for the more "important and medically necessary services." The challenged section is as follows:

> Section 7. Subsidizing of Abortions.—
>
> Since it is the public policy of the Commonwealth not to use public funds to pay for unneeded and unnecessary abortions, no abortion shall be subsidized by any State or local governmental agency in the absence of a certificate of a physician, filed with such body, stating that such abortion is necessary in order to preserve the life of health of the mother.
>
> Nothing contained in this section shall be interpreted to restrict or limit in any way, appropriations made by the Commonwealth or a local governmental agency to hospitals for their maintenance and oper-

ations, or for reimbursement to hospitals for services performed.

With respect to plaintiffs' challenge concerning an alleged discrimination against the indigent pregnant female who chooses abortion, we note that the plaintiffs make two basic attacks on Section 7: 1) the provision is inconsistent with the Social Security Act, and therefore invalid under the Supremacy Clause, and 2) the provision violates the Equal Protection Clause by creating an unlawful distinction between indigent women who choose to carry their pregnancies to birth and indigent women who choose to terminate their pregnancies by abortion. This Court being mindful of the Supreme Court's preference for statutory resolution of cases, as opposed to constitutional resolution of cases, will first consider the challenged provision on the basis of Title XIX of the Social Security Act. See *Hagans v. Lavine*, 415 U.S. 528, 94 S.Ct. 1372, 39 L.Ed. 2d 577 (1974).

State defendants admit that it is the policy of the state of Pennsylvania, with respect to its Title XIX program, to pay the full costs of term delivery for eligible women. It is also the policy of the state, as evidenced by Section 7 of the Act, not to pay any of the costs of an abortion for eligible women, unless the abortion is necessary in order to preserve the life or health of the mother.

One of the questions before us is whether Pennsylvania's policy governing payment for the costs of abortions is compatible with Title XIX? Subsequent to the trial in this matter, the U.S. Court of Appeals for the Third Circuit decided the case of *Doe v. Beal*, Nos. 74-1726 and 74-1727 (3d Cir. July 21, 1975) (en banc). In *Doe v. Beal, supra*, the Third Circuit held that a non-statutory state policy prohibiting payment for non-therapeutic abortions[12] is in conflict with Title XIX of the Social Security Act. Accordingly, we apply the law of the Circuit and enjoin the enforcement of Section 7 of the Act insofar as it restricts the payment of Title XIX funds for the costs of an abortion.

However, Section 7 of the Act does not confine itself to Title XIX funds, but rather it applies to any subsidy from a state or local governmental agency. Therefore, our above resolution of the statutory challenge to Section 7 does not completely dispose of the matter, and we must now determine plaintiffs' constitutional challenge to the section.

Plaintiffs contend that since pregnant women have only the option of either birth or abortion, a distinction between indigent pregnant women who choose to carry their

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[12]As discussed in Doe v. Beal, supra, the state's policy under its Medical Assistance program prior to the enactment of the Abortion Control Act was that abortions would only be paid for in the following situations:

1. There is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother;

2. There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency; or

3. There is documented medical evidence that a continuance of a pregnancy resulting from legally established statutory or forcible rape or incest, may constitute a threat to the mental or physical health of a patient;

4. Two other physicians chosen because of their recognized professional competency have examined the patient and have concurred in writing; and

5. The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals.

pregnancies to birth and indigent pregnant women who choose to terminate their pregnancies by abortion, deprive women who choose abortion of their rights guaranteed by *Roe* and the Equal Protection Clause of the Fourteenth Amendment.

The state admits that it provides medical payments for indigent women who carry to term, but not for indigent women who choose to terminate their pregnancy by abortion. Under the Act, an indigent pregnant woman, who is refused medical assistance for a first trimester abortion, may proceed to give birth and the state will pay the reasonable medical expenses incident to the birth. We observe that in this situation the state pays a greater sum of money and clearly does not "conserve limited state resources."

Thus, without realizing any fiscal savings for the state, the Act coerces some pregnant women into a decision to give birth. Of course, we realize that not all pregnant women will forfeit their right to obtain an abortion and some may in fact obtain the abortion without the use of state funds. We note that the state has not attempted to justify Section 7 by arguing that it is less expensive for a pregnant woman to carry to term than for her to have an abortion, and the evidence of records suggests the contrary. Another three-judge court in this Circuit has also concluded that childbirth is costlier than abortion. *Doe v. Wohlgemuth,* 376 F.Supp. 173, at 187 (W.D. Pa. 1973), *aff'd. on other grounds, Doe v. Beal, supra.*

The principal state contention is that "the existence of a fundamental right to decide to have an abortion is not sufficient to order that the means to implement the decision be provided by the State." Thus the argument of Pennsylvania is that the Constitution does not require the state to finance the exercise of a fundamental right. We agree with this general proposition of law, but it does not resolve the issue before us. The issue is whether Pennsylvania may make the exercise of a fundamental right, i.e. a decision to have an abortion, the operative factor in cutting off medical benefits to indigent pregnant women, while continuing benefits to those who decide to give birth. We hold that Section 7 of the Act which penalizes the decision to have an abortion is unconstitutional.

As a threshold matter, we determine that the appropriate standard by which Section 7 is to be measured is the compelling state interest test and not the rational relationship test. The determination by the Supreme Court in *Roe* that it is only when the state interest reaches certain compelling points that the state may regulate with respect to maternal health and fetal life clearly suggests that any state regulation, which burdens the right of the pregnant woman to decide whether to give birth or to terminate a pregnancy, must be necessary to promote a compelling governmental interest. Indeed, the Supreme Court has determined in both pre-*Roe* and post-*Roe* decisions that the compelling state interest test must be applied when fundamental rights are infringed. *Shapiro v. Thompson,* 394 U.S. 618, 89 S.Ct. 1322, 22 L.Ed. 2d 600 (1969) and *Memorial Hospital v. Maricopa County,* 415 U.S. 250, 94 S.Ct. 1076, 39 L.Ed. 2d 306 (1974).

In *Shapiro,* the Supreme Court found unconstitutional state statutes denying welfare assistance to residents who had not resided within the jurisdiction for at least one year immediately preceding their applications for public assistance. The Court in deciding that the com-

pelling interest test applied stated at 394 U.S. 634, 89 S.Ct. 1331:

> At the outset, we reject appellants' argument that a mere showing of a rational relationship between the waiting period and the . . . permissible state objectives will suffice to justify the classification . . . the waiting period provision denies welfare benefits to otherwise eligible applicants solely because they have recently moved into the jurisdiction. But in moving from state to state or to the District of Columbia appellees were exercising a constitutional right, and any classification which serves to penalize the exercise of that right, unless shown to be necessary to promote a compelling governmental interest, is unconstitutional.

In the post-*Roe* decision, of *Memorial Hospital v. Maricopa County, supra,* the Supreme Court has recently reaffirmed the principle of *Shapiro.* In *Maricopa County* a durational county residence requirement for eligibility for non-emergency free medical care for indigents was measured by the compelling state interest test and was held to be unconstitutional.

Here, as in *Shapiro* and *Maricopa County,* we deal with governmental benefits for indigents. Here, we deal with a particular subclass of indigents, those who are pregnant. Here as in *Shapiro* and *Maricopa County,* those indigent pregnant women who exercise a right protected by the Constitution, i.e. to have an abortion, are denied the governmental benefit solely as a consequence of the exercise of that right. Accordingly, in reliance on *Roe, Shapiro,* and *Maricopa County,* we hold that although an indigent pregnant woman may not have a fundamental

right to require the government to subsidize an abortion where the state so classifies as to deprive particular indigents of the benefits otherwise available, as a consequence of their exercise of a fundamental right, the state legislation must be measured by the compelling state interest test and the state must demonstrate that its classification scheme promotes a legitimate governmental objective.

The only objective asserted by the state is that its scheme of medical reimbursement is designed to pay only for the more "important and medically necessary services," in an effort to conserve limited state resources. The state does not contend that the costs associated with an abortion are greater than the costs associated with birth, rather the state argues that birth is somehow more medically necessary than abortion. In todays society all pregnant women need medical treatment regardless of whether the women's decision is to give birth or to terminate the pregnancy. There is no physiological or psychological basis in the case of a pregnancy to label the medical services attendant to birth more important or necessary than those attendant to abortion. The language of the statute indicates that the distinction here contended for by Pennsylvania rests upon a social policy preference and not a medical determination. Of course, a statute which discriminates in terms of illegal classifications and penalizes the exercise of a constitutional right is unconstitutional even though it reflects the social value judgment of the legislature. As the Supreme Court observed in *Shapiro, supra,* 394 U.S. at 631, 89 S.Ct. 1329:

> Thus, the purposes of deterring the immigration of indigents cannot serve as justification for the

> classification created by the one-year waiting period, since that purpose is constitutionally impermissible. If a law has "no other purpose . . . than to chill the assertion of constitutional rights by penalizing those who choose to exercise them, then it [is] patently unconstitutional." [Citation omitted.]

Perhaps the state may constitutionally choose not to pay for any medical services related to the condition of pregnancy. However, once the state decides to provide medical payments for those who choose one alternative medical treatment for pregnancy, i.e. childbirth; it cannot penalize those who choose the other constitutionally protected alternative medical treatment, i.e. abortion, because of an alleged fiscal interest. As Mr. Justice Brennan observed in his opinion for the Court in *Shapiro, supra,* 394 U.S. at 633, 89 S.Ct. at 1330:

> We recognize that a state has a valid interest in preserving the fiscal integrity of its programs. It may legitimately attempt to limit its expenditures, whether for public assistance, public education, or any other program. But a State may not accomplish such a purpose by invidious distinctions between classes of its citizens. It could not, for example, reduce expenditures for education by barring indigent children from its schools. Similarly, in the cases before us, appellants must do more than show that denying welfare benefits to new residents saves money. The saving of welfare costs cannot justify an otherwise invidious classification.

All post-*Roe* case authority supports the proposition that statutes or administrative policies which restrict reimbursement for abortions are unconstitutional. *Doe v. Wohlgemuth, supra, aff'd on other grds., Doe v. Beal, supra; Doe v. Rose,* 499 F.2d 1112 (10th Cir. 1974); *Wulff v. Singleton,* 508 F.2d 1211 (8th Cir. 1975); and *Doe v. Rampton,* 366 F. Supp. 189 (1973).

For the reasons stated above, we find that Section 7 of the Abortion Control Act is in conflict with Title XIX of the Social Security Act. As to non-Title XIX funds, Section 7 violates the Equal Protection Clause of the Fourteenth Amendment and is inconsistent with the Supreme Court's decision in *Roe;* accordingly, we hold that Section 7 is unconstitutional.

IX. Regulations

Section 8 of the Act gives the Department of Health the authority to make rules and regulations with respect to the performance of abortions and the facilities in which abortions are performed. Plaintiffs contend that this provision intrudes upon the pregnant woman's fundamental right of privacy. The challenged section is as follows:

> Section 8. Regulations.—
>
> The Department of Health shall have power to make rules and regulations pursuant to this act, with respect to performance of abortions and with respect to facilities in which abortions are performed, so as to protect the health and safety of women having abortions and of premature infants aborted alive. Said rules and regulations shall include, but not be limited to procedures, staff, equipment, and laboratory testing requirements for all facilities offering abortion services.

Plaintiffs' assault on Section 8 is premature. This provision of Act 209 is merely an enabling provision granting the Department of Health the authority to make rules and regulations in the abortion area. At the present time, no regulations are before us which have been enacted by the Department of Health; thus, there are no regulations we can scrutinize to determine whether or not a constitutional deprivation has occurred. On the basis of the record before us, we will not assume that the regulations, if any, which may be enacted pursuant to the Act will be inconsistent with the Supreme Court's decisions in *Roe* and *Doe*[13]. Consequently, we find Section 8 not to be unconstitutional on its face.

X. *The Choice of Appropriate Relief*

In our consideration of the Abortion Control Act, we have severed provisions of the Act which we find to be unconstitutional and have denied plaintiff's request that we declare the whole Act unconstitutional as representing a legislative intent to control in an impermissible manner the fundamental right of a pregnant woman in consultation with her physician to decide to have an abortion. It is clear to this Court that the sections declared unconstitutional or inconsistent with a federal statute, if enforced against plaintiffs and the class they represent, would cause irreparable injury to plaintiffs. We recognize that this Court should enter only a declaratory judgment, and not the injunctive relief requested, if we are satisfied that

[13]E.g., in Roe, see discussion at 410 U.S. 163, 93 S.Ct. 732. And, see Friendship Medical Center, Ltd. v. Chicago Board of Health, 505 F.2d 1141 (7th Cir. 1974), cert. den., 95 S.Ct. 1438 (1975).

defendants will acquiesce in the decision holding the challenged provisions of the Act unconstitutional. *Poe v. Gerstein*, 417 U.S. 281, 94 S.Ct. 2247, 41 L.Ed. 2d 72 (1974); *Douglas v. Jeannette*, 319 U.S. 157, at 165, 63 S.Ct. 877, at 881, 87 L.Ed. 1324 (1943); *Dombrowski v. Pfister*, 380 U.S. 479, at 484-485, 85 S.Ct. 1116, at 1119-20, 14 L.Ed. 2d 22 (1965); *Zwickler v. Koota*, 389 U.S. 241, at 253-254, 88 S.Ct. 391, at 398, 19 L. Ed. 2d 444 (1967); *Roe v. Wade*, supra, 410 U.S. at 166-67, 93 S.Ct. at 733, 35 L.Ed. 2d 147 (1973).

In the instant case, counsel for defendant Fitzpatrick has stated in open court that defendant Fitzpatrick will abide by any declaratory judgment entered by this Court. With respect to the state defendants, we have a more difficult problem. We are aware of the fact that the Abortion Control Act was enacted by the Pennsylvania legislature over the veto of the Governor. The Governor's action in vetoing the bill as presented to him was based on the opinion of his then Attorney General that two sections of the Act were clearly unconstitutional on their face[14], and several other sections were of questionable constitutionality[15]. With this background we would ordinarily assume that the Governor would direct the Executive Departments to acquiesce in our declaration that certain sections of the Act are unconstitutional. However, in open court, but unfortunately off the record, counsel for the state defendants advised us that counsel could not give this Court any assurance that the state de-

[14]Namely, Sections 3(b)(i) and 3(b)(ii).

[15]Namely, the definition of "informed consent" found in Section 2, Sections 3(a), 6(f), 7, and 5(a).

fendants would abide by a declaratory judgment. Accordingly, the record does not support an assumption on our part that the state will acquiesce in a declaratory judgment decision and, therefore, we enter injunctive relief in favor of the plaintiffs and against all defendants as to the sections of the Act declared unconstitutional.

* * *

Informed Consent

For the reasons set forth in the separate opinion filed by Judge Adams and, as to that part dealing with informed consent, joined in by Judge Newcomer, the challenged sections of the Act relating to informed consent are declared to be constitutional. I have filed a separate dissenting view.

TO THE CLERK:

Please file the foregoing Opinion.

Clifford Scott Green
District Judge

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 74-2440

Planned Parenthood Association, et al.
Plaintiff

Obstetrical Society of Philadelphia
Intervenor Plaintiff

vs.

F. Emmett Fitzpatrick, Jr., and Frank S. Beal
Defendants

and

Robert P. Kane and The Commonwealth of Pennsylvania
Intervenor Defendants

GREEN, *District Judge.*

Dissenting as to the decision on Informed Consent.

I dissent from the decision of the Court holding the informed consent provisions of the Abortion Control Act constitutional. I believe subsections (i) and (ii) of Section 2 and the informed consent criminal sanction provisions in Section 3 are unconstitutional because the provisions invade the privacy of the physician-patient relationship and violate the Fourteenth Amendment by regulating abortions more stringently than other medically indistinguishable procedures. The Act provides in relevant part:

Section 2. Definitions.—As used in this act:

. . . .

"Informed consent" means a written statement, voluntarily entered into by the person upon whom an abortion is to be performed, whereby she specifically consents thereto. Such consent shall be deemed to be an informed consent only if it affirmatively appears in the written statement signed by the person upon whom the abortion is to be performed that she has been advised (i) that there may be detrimental physical and psychological effects which are not forseeable, (ii) of possible alternatives to abortion, including childbirth and adoption, and (iii) of the medical procedures to be used. Such statement shall be signed by the physician or by a counselor authorized by him and shall also be made orally in readily understandable terms in so far as practicable.

. . . .

Section 3. Consent to Abortion; Limitations on Public Officials.—

(a) No abortion shall be performed upon any person in the absence of informed consent thereto by such person. Notwithstanding the foregoing provisions of this subsection, an abortion may be performed on any person if, in the medical judgment of a licensed physician, an abortion is immediately necessary to preserve the life of the woman and the woman is unable to give consent.

. . . .

(e) Whoever performs an abortion without consent as required in subsections (a) and (b) of this section shall be guilty of a misdemeanor of the first degree.

The opinion of Judge Adams states that the informed consent requirements of the Act merely codify Pennsylvania informed consent requirements, citing as authority *Dunham v. Wright*, 423 F.2d 940 (3d Cir. 1970). It is, of course, essential that the abortion procedure not be singled out for harsher regulation than other medical procedures. *Doe v. Bolton*, 410 U.S. 179, at 195-200, 93 S. Ct. 739, at 749-51, 35 L.Ed. 2d 201 (1973).

I agree with Judge Adams that *Dunham* correctly sets forth the law of Pennsylvania in regard to informed consent; however, the requirements of subsections (i) and (ii) of Section 2 far exceed the informed consent requirements of Pennsylvania law as set forth in *Dunham*. The fact that the requirements of the Abortion Control Act are not merely a codification of Pennsylvania law is readily apparent when one contrasts the Pennsylvania law as set forth in *Dunham* with the requirements of the Act. Significantly, if the absolute disclosure requirement of the Act had been applied to the facts of *Dunham*, an opposite holding would have been compelled.

The Third Circuit decided in *Dunham*, in an opinion by Judge Adams, that liability, as a matter of law, did not result from a failure of the surgeon to advise the patient that there was a percentage risk of death associated with the operation. In this regard, Judge Adams stated at 423 F.2d 946:

> Although this omission can be a serious one, in the setting of this case it does not require us to hold

as a matter of law that the defendants failed to discharge their burden of disclosure. In *Grunnagle,* the Court did not direct a verdict for the plaintiff although the record indicates that the defendant physician may have failed to inform the patient of a 10 to 15% risk that he would be worse after the operation; instead the Court said whether there was an informed consent was a question for the jury.

A reading of the Abortion Control Act clearly reveals that absolute liability, civil and criminal, is imposed for the failure to give to the patient the statutorily required information. When this section is compared with the holding in *Dunham,* I believe it is erroneous to say that the Act merely codifies the Pennsylvania law on informed consent; clearly, it adds new, absolute liability requirements applicable only to the performance of an abortion.

Contrast, also, the holding in *Dunham* that consent is informed if it may be inferred from the evidence that the patient was aware of an alternative treatment even though the physician did not advise the patient of the alternative medical treatment to surgery. It is clear that under Pennsylvania law the awareness of the patient is the crucial issue. However, under the Abortion Control Act, the failure to give the required information results in liability even though the patient is clearly aware of the information and of all the alternatives. Obviously, a patient who consults a physician knows that the alternative to abortion is childbirth; indeed, it is her knowledge of this alternative which impels her to seek an abortion in the first place. Nevertheless, under the Abortion Control Act a doctor commits a crime if he fails to advise her in accordance with the Act of the alternative of childbirth. Thus, patient awareness of the alternatives is a defense to all informed consent litigation except when it arises out of the performance of an abortion.

Furthermore, in *Dunham* the Court decided the law of Pennsylvania to be that "disclosure of alternative treatment means disclosure of alternatives for the particular patient and not a recital of medical case book theory." However, the Abortion Control Act requires the physician to recite legislative directives to his patient even if he does not believe them to be applicable to the particular patient. Such a requirement is not applicable to any other medical procedure.

In addition, the Act requires the doctor to advise all abortion patients of an alternative unconnected with medicine, i.e. adoption. I am aware of no other medical procedure where a physician is required, as a matter of informed consent, to advise a patient of a subject not included within his medical knowledge.

Finally, but most importantly, the physician is subject to criminal prosecution for failure to follow the provisions of the Act concerning informed consent. It is undisputed that only as to the performance of an abortion is failure to obtain an informed consent a crime in Pennsylvania.

Because of the aforesaid distinctions, applicable only when informed consent involves abortion, I believe the statutory provisions relating to informed consent, insofar as they require the information mandated in subsections (i) and (ii) are unconstitutional in that they single out for restriction the abortion procedure from all other similar surgical procedures and are unnecessary to protect

the state's important and legitimate interest in the health of the mother. The consent provisions of subsections (i) and (ii) are invalid because they legislatively mandate the elements that are to constitute an informed consent in the abortion field; yet the state has referred the Court to no other similar medical procedure with comparable consent requirements. Moreover, the state has referred the Court to no other medical procedure which has a criminal penalty for failure to obtain an informed consent. No rational or legally cognizable basis for these distinctions has been offered. The extra layer of regulation which these provisions impose in the abortion area is unreasonably burdensome of the patients' and physicians' rights under the Fourteenth Amendment of the Constitution. Cf., *Doe v. Bolton, supra,* 410 U.S. at 195-200, 93 S.Ct. at 749-51; *Word v. Poelker,* 495 F.2d 1349, at 1351-52 (8th Cir. 1974); *Hodgson v. Anderson,* 378 F. Supp. 1008, at 1018 (D. Minn. 1974); and *Friendship Medical Center, Ltd. v. Chicago Board of Health,* 505 F. 2d 1141, at 1152-53 (7th Cir. 1974).

Also, it is clear under *Roe v. Wade,* 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed. 2d 147 (1973), that it is only at the end of the first trimester that the state's interest in maternal health becomes compelling and that the state may only regulate abortions after the first trimester if it can demonstrate that the regulation reasonably relates to the preservation and protection of maternal health. However, since the Act's informed consent requirements of subsections (i) and (ii) of Section 2 apply to the first trimester, the Act is for this reason alone inconsistent with the Supreme Court's decisions of *Roe* and *Doe. Doe, supra,* 410 U.S. at 195, 93 S.Ct. at 749.

Finally, the suggestion is made that a physician may legally satisfy subsections (i) and (ii) of Section 2, by first ritualistically following the requirements of the subsections and then negating the instructions by advising the patient he does not believe the required information is applicable to her condition. However, this process requires the physician to warn a patient of risks which he may not believe to exist and to inform the patient of alternatives, including adoption (clearly a non-medical alternative) which he may not believe to be available. Such a process is demeaning to the physician; confusing to the patient; and to some extent, deprives the patient of the honest opinion of her physician, which is essential for a meaningful consultation. No other medical procedure is so burdened.

I do not agree that the Act may be interpreted as merely requiring the giving of the requisite information and then permitting the recall of the instruction as inappropriate to the particular patient. The text of the Act does not support such an interpretation. To the extent that a physician, faced with criminal sanctions, is required to rely on such a speculative interpretation, the criminal provisions would appear to be unconstitutionally vague.

For the reasons set forth above, I would hold subsections (i) and (ii) of Section 2's definition of "informed consent", Section 3(a) of the Act to the extent that it incorporates the requirements of subsections (i) and (ii), and Section 3(e) of the Act to the extent that it applies to the requirements of Section 3(a) and subsections (i) and (ii), to be inconsistent with the Supreme

Court's decisions in *Roe* and *Doe*, and therefore unconstitutional.

TO THE CLERK:

Please file the foregoing Opinion.

Clifford Scott Green
District Judge

ADAMS, Circuit Judge, concurring and dissenting

The court is here obliged to card the tangled fibres of protected private rights and legitimate state interests in the troubling and unclear area of abortion regulation. Powerful responses are evoked by the subject of abortion and it is open to some doubt whether the courts are the institution best equipped to resolve the complex societal interests that exist in the abortion field. Nonetheless, the courts have been thrust into that role and it is incumbent on us to adjudicate the constitutional questions presented here.

The Supreme Court in *Roe*[1] and *Doe*[2] has decreed that the state may not prohibit the exercise of a woman's fundamental right to obtain an abortion—at least in the first two trimesters. A new generation of problems was spawned in the wake of those two decisions, respecting the degree to which authority to regulate abortions, or to affect them, is retained by the state. In defending the Abortion Control Act of 1974, Pennsylvania takes the position that broad power continues to be vested in the

[1]Roe v. Wade, 410 U.S. 113 (1973).
[2]Doe v. Bolton, 410 U.S. 179 (1973).

state to monitor abortion practices. By contrast, plaintiffs maintain that *Roe* and *Doe* and their implications leave the state a more limited authority to legislate than Pennsylvania has sought to exercise.

Roe and *Doe* now form part of the backdrop of our law, and no purpose would be served here by discussing the arguments that have been laid to rest by those decisions. In turning to deal with the fresh problems that have arisen, we must be mindful that the acts of a popularly chosen legislature are not to be lightly invalidated—surely, not on the basis of what a court or a particular judge deems wise or desirable from the standpoint of public policy. Furthermore, we should be keenly aware that *Roe* and *Doe* were innovative decisions, and the subtlety of the ultimate fabric of law affecting abortions is perhaps not yet discernible. I am, therefore, reluctant to leap ahead too quickly to interdict states from legislating respecting abortions when, in the accumulative informed judgment of the legislators, such enactments are necessary to serve legitimate interests of the populace.

It is with such admonitions in mind that I am unable to join in the views expressed by Judge Green in the following respects: I would not conclude that the informed consent provision defined in Section 2 and required by Section 3 is unconstitutional; nor would I find unconstitutional the requirement that consent for a minor's abortion must be obtained from a parent or person in loco parentis. And although in accord with the ultimate result reached by the majority on the question of viability, it seems fitting to express my somewhat differing views on that issue.

1. *Informed Consent*

Indisputably, informed consent would be necessary under Pennsylvania law before any medical procedure—including an abortion—may legally be performed.[3] To a considerable extent, the legislature has codified the informed consent requirement in section 3 of the Act and mandates that in the abortion field it be in writing.[4]

Plaintiffs assert that this requirement of written consent chills the right to choose to abort, and improperly interferes with the woman-physician relationship by interposing a state-ordained litany into the doctor's professional judgment regarding the information he or she finds it appropriate to tell a patient.[5]

No evidence has been adduced that persuades me that the information a doctor is requested to give under the statute would measurably chill the exercise of the abortion option. Therefore, the rational relationship test seems applicable,[6] and the burden lies with the plaintiffs to demonstrate the invalidity of this section.

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[3]Dunham v. Wright, 423 F.2d 940 (3d Cir. 1970).

[4]Parenthetically, it may be noted that the directive that the consent be in writing operates, inter alia, for the protection of the doctor against subsequent claims that informed consent was absent.

[5]In Doe v. Bolton, supra p. 198-200, Justice Blackmun criticized the practice of the State of Georgia in requiring two physicians to agree before there may be an abortion, and states that such practice "has no rational connection with a patient's need, and unduly infringes on the physician's right to practice." However, no reference is made in the opinion to the question of informed consent as such.

[6]San Antonio Independent School District v. Rodriguez, 411 U.S. 1, 28 (1973).

Employing that test, several reasonable bases appear to justify the required informed-consent provision. There are particular practical circumstances pertaining to the delivery of abortion services that might well generate substantial concerns on the part of the legislature. Accordingly, contrary to the assertions of the plaintiffs, separate attention addressed to abortion care does not appear per se unconstitutional under the Equal Protection Clause.[7] Rather, the separate treatment is suggested not by the choice of abortion, but by the realities of the system that provides abortions.

Abortions are frequently obtained in a specialized clinic or hospital department where a woman is removed from familiar medical surroundings. Most frequently the abortion is not done by a woman's regular doctor. The procedures, perhaps routine for those performing them, will probably be totally unlike any others theretofore undergone by the patient. In addition, as the record in this case indicates, the woman may well be experiencing considerable emotional anxiety.

Generally, the abortion decision is somewhat hurriedly arrived at and executed. It, in many cases, may be attended by a reticence that works to close off ordinary avenues of information to the patient either from friends or from family members.

The state under such circumstances might understandably wish to be certain that each woman be given the facts regarding her condition, her options, the abortion procedure to be performed and the possible future

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[7]Plaintiffs appear to acquiesce in this, for no attack is leveled on the requirement that the consent be written.

consequences of the choice she makes. Like the licensing of facilities, the regulations, and the record-keeping provisions, the informed consent requirement may well be an attempt by the state to monitor the quality of medical care received by women procuring abortions.

To the extent the requisite information respecting the alternatives to abortion are inappropriate in any particular case, the physician is not prohibited from so indicating to the patient *en passant*. A doctor may conclude that, in his or her professional judgment, it is unlikely that a patient will experience "detrimental physical and psychological effects which are not foreseeable."[8] In that event, while telling a patient that the law requires such advice, the Act does not foreclose the physician from putting this statement in perspective for a given patient by reassurances, or by comparing the risks of other options. Proper counseling, it would appear, could incorporate the information demanded by the state and tailor the comprehensive advice to the individual case.

Whether such a provision is prudent or imprudent or whether it is wise or unwise to provide a penalty in the nature of a misdemeanor when the physician does not supply the advice in question, is not a matter for the court to decide. Rather, it is within our province to say only whether the requisite consent is in no way related to legitimate state interests. This I am unable to do.

2. Consent by Parent or Person In Loco Parentis for Abortion on a Minor

Plaintiffs contend that the state by requiring adult consent to the performance of an abortion on an unemancipated pregnant female under the age of 18 forges an unconstitutional veto power over a young woman's fundamental right to abort. In many cases the effect of requiring consent, the argument continues, will be to deny the right totally, at the whim of a dissident parent.

[8]Abortion Control Act, Act No. 209, 35 P.S. §6601.

The provision is defended on the twofold basis that it serves a substantial state interest in the welfare of the minor regarding the serious decision to abort, and that it assures a parental role in the abortion choice of a child. Although I harbor some reservations regarding the latter justification for the requirement, under the statutory reading that appears reasonable to me I find the rationale adequate to sustain the restriction.

No explicit demarcation between adult and child is written in the Constitution, and it is by now clear that minors in many circumstances are vested with constitutional rights, though frequently they are not coterminus with the rights of adults. For example, Tinker v. Des Moines School District[9] established that students enjoy First Amendment rights of expression. In re Gault[10] held that fundamental due process rights appropriate to criminal proceedings must be applied in the quasi-criminal setting of a minor's delinquency hearing. And other Supreme Court decisions have clarified additional constitutional rights of minors.[11]

[9]393 U.S. 503, 514-515 (1969) (nondisruptive political protest). *See also* West Virginia v. Barnett, 319 U.S. 629 (1943) (salute to flag).

[10]387 U.S. 1 (1967).

[11]*See, e.g.*, Yoder v. Wisconsin, 406 U.S. 205 (1972) (religion); Ginsberg v. New York, 390 U.S. 629 (1968) (first amendment, obscenity); Prince v. Massachusetts, 321 U.S. 158 (1944) (religion); West Virginia v. Barnett, 319 U.S. 624 (1943) (due process).

There are at least two legitimate interests that a state may promote in enactments respecting minors. Legislation may be upheld either as an expression by the body politic for the protection of children or in order to secure claims of parental control over the care and up-bringing of children.[12]

Acting to further these ends, the state is empowered to legislate and, in some cases, to circumscribe the conduct of minors to a greater extent than it can legislate for adults.[13] Where the circumstances so require, the expression of protected rights asserted on behalf of minors may be curtailed or even prohibited.[14]

Beyond the freedom to determine whether and when to have a family, parents generally have broad power to make decisions affecting the schooling and religious upbringing of their offspring.[15] On occasion, the interests of the state in the minor and that of the individual parent have been at odds, and in such event the interests of both parties must then be weighed.[16]

There is no clash in the present case between the state and parent, or between the state and minor. Rather, the state seems to take a rather neutral attitude toward abortions for minors, neither prohibiting them altogether

[12]See *Ginsberg*, 390 U.S. at 639-40.

[13]Prince v. Massachusetts, 321 U.S. 158 (1944).

[14]*Prince*, supra note 3; *Ginsberg*, supra note 3.

[15]*Yoder*, supra note 3; Pierce v. Society of Sisters, 268 U.S. 510 (1925) (state could not prohibit private schools); Meyer v. Nebraska, 262 U.S. 390 (1923) (state could not prohibit the teaching of foreign languages in schools).

[16]*Compare Yoder*, supra note 3 with *Prince*, supra note 3.

nor emancipating the minor to make the grave abortion decision without the concurrence of a responsible adult.

Plaintiffs here, on behalf of the minors, assert a right to abort as freely as an adult. While there is no Supreme Court precedent governing the result when a minor independently claims fundamental rights consented to by neither parents nor the state, it does appear from the cases that, between them, the state and parent may exercise considerable control over a minor's activities. Faced with a challenge to a state statute prohibiting minors from selling publications on the streets, the Supreme Court in Prince v. Massachusetts[17] upheld the statute against claims bottomed on both the First Amendment freedom of religion and on parental due process. Under *Prince*, the state would appear to have the power to delimit the exercise by minors of protected freedoms if adequate foundation exists for the state regulation.

Similarly, *Tinker* upheld the notion that special circumstances pertaining to their situation might admit of a constricted exercise of First Amendment freedoms by minors in school.

The Supreme Court in Ginsberg v. New York[18] endorsed the concept that the scope and content of a protected right could be variable depending on whether the person asserting the right was a minor. The state statute sustained in *Ginsberg* prohibited the sale to minors of sexually explicit publications that were not obscene as to adults. The Court was careful to observe[19] that, while

[17]321 U.S. 158 (1944).

[18]390 U.S. 629 (1969).

[19]390 U.S. at 639.

sale to minors was prohibited, parents who so desired were not precluded from making such publications available to their children. *Ginsberg* seems somewhat parallel to the present situation, where the state provides that minors may not independently seek out access to sensitive matters (lascivious publications in *Ginsberg*, abortion in the case here), but with parental permission the state maintains no further independent interest in protecting the minor. There does appear to be some precedent therefore for enabling a state to condition a minor's access to a right—protected with respect to adults—upon an adult's consent.

The consent provision in the statute before us is open to a somewhat broader interpretation than that assumed by the plaintiffs and the majority. This is so since, in addition to consent by a parent or legal guardian, the statute provides for permission to be given by a person in loco parentis. The court has been directed to no evidence indicating that a restrictive interpretation of the phrase "person in loco parentis" was intended by the legislature. It would thus appear that consent would be acceptable from a responsible and caring adult who has a close relationship with the young pregnant woman.[20]

This more generous interpretation of the language "in loco parentis" would satisfy the interest of the legislature that the minor not be rushed into an abortion in

[20] "The principle is old and deeply imbedded in our jurisprudence that this Court will construe a statute in a manner that requires decision of serious constitutional questions only if the statutory language leaves no reasonable alternative." U.S. v. Gambling Devices, 346 U.S. 441 (1951), at p. 448. *See also* Driscoll v. Edison, 307 U.S. 104, 105 (1939).

which she was inadequately counseled, ignorant of the facts or unsupported psychologically. It would assure that some mature person with an interest in and relationship to the young pregnant woman would participate in her decision. Requiring consent affords a reasonable means to be certain that the adult undertake a degree of responsibility for the minor's resolution to abort.

The abortion decision should be made as intelligently as possible. Inevitably, the situation is accompanied by stress and urgency. The minor is, by the very fact of age, relatively inexperienced in making decisions of the type contemplated here. There is a legitimate interest on the part of the state in protecting the physical and emotional environments of the young woman. The state may permissibly conclude that it is in the best interest of the minor to assure that an adult has helped the young person arrive at an informed judgment.[21]

Accordingly, at least as it is interpreted in this opinion, it appears to me that the requirement that a parent or person in loco parentis consent to a minor's abortion is not unconstitutional.

3. *Viability*

I agree with the majority that the term viability is not sufficiently susceptible of objective and predictable definition for criminal penalties to turn on what is necessarily an after-the-fact extrapolation whether a fetus was viable at the time of an abortion.

Nevertheless, the dilemma suggested by the result we reach today warrants some attention. Indisputably, the

[21] 390 U.S. at 639.

state has a profound interest in preserving human life, including the life of a viable but unborn fetus.[22] It therefore would seem to lie within the legitimate exercise of the police power for the state to prohibit the destruction of such viable fetal life.

Difficulty arises in formulating a criminal sanction respecting late-term abortion because, based on the record in this case, the point at which the fetus matures to viability is not universally agreed upon as a matter of medical definition. The legal definition of the instant at which life occurs to a fetus, as a standard to guide professional conduct, appears vague because it derives from a medical interpretation that lacks the specificity required for criminal sanctions.

As observed by the majority, there is a consensus regarding the applicable guidelines for determining viability—in particular the length of time since the last menses and the size of the fetus as determined by abdominal measurement of the mother. However, three principal factors render the viability definition uncertain. First, the diagnosis is not foolproof but is an estimate of fetal age. Second, whether any given fetus would survive a premature delivery cannot be ascertained in advance. Third, the evidence revealed that medical practitioners accept different statistical survival rates as determinative of viability. In the view of some of the physicians who testified, if a fetus of a certain gestatioral age had survived in the annals of medical history, such period set a base age for viability. For other doctors, unless a fetus reached a size where a 10% likelihood of survival could

[22] *Roe*, supra note 1; *Doe*, supra note 2.

be expected, the point of viability, in their judgment, had not been achieved.

In the situation covered by the statute, until the line demarcating criminality is crossed, the conduct involved is constitutionally protected. The statute is assailed because the conduct in very many situations when performed cannot readily be identified as criminal or non-criminal.

Grayned v. City of Rockford[23] addressed a statute regulating picketing, allegedly defective on vagueness grounds. There the Supreme Court described the vice of vagueness as follows:

> . . . Vague laws offend several important values. First, because we assume that man is free to steer between lawful and unlawful conduct, we insist that laws give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly. Vague laws may trap the innocent by not providing fair warning. Second, if arbitrary and discriminatory enforcement is to be prevented, laws must provide explicit standards for those who apply them. A vague law impermissibly delegates basic policy matters to policemen, judges, and juries for resolution on an *ad hoc* and subjective basis, with the attendant dangers of arbitrary and discriminatory application. Third, but related, where a vague statute "abut[s] upon sensitive areas of basic First Amendment freedoms," it "operates to inhibit the exercise of [those] freedoms." Uncertain meanings inevitably lead citizens to " 'steer far wider of the unlawful zone' . . .

[23] 408 U.S. 104 (1972).

than if the boundaries of the forbidden areas were clearly marked."[24]

Until viability, a woman has a fundamental right to abort but, once having traversed the viability line, the state has a compelling interest in restricting abortion. Normal caution to avert potentially criminal activity will produce the effect of chilling the exercise of the protected right. For this reason a proscriptive statute must be narrowly drawn or else it will, as a practical matter, invade the protected right.[25]

The Pennsylvania Abortion Statute is unlike others whose broad language has been saved by repeated applications that have narrowed and supplied meaning by interpretation.[26] The problem here is not that the legal definition of the criminal behavior is broad, but that it applies a standard, viability, malleable at the time of the conduct and respecting which experts do not agree.

It is true that the Supreme Court has held that the critical mark in time for purposes of forbidding abortion is viability. Because the definition of the threshold of viability is riddled with the uncertainties cited above, however, that concept is not an adequate guide for phy-

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[24]408 U.S. at 108-09 (footnotes omitted), quoting Baggett v. Bullitt, 377 U.S. 360, 372 (1964); Cramp v. Board of Public Instruction, 368 U.S. 278, 287 (1961).

The seminal article on vagueness is Amsterdam, "The Void for Vagueness Doctrine in the Supreme Court," 109 U. Pa. L. Rev. 67 (1960).

[25]*See for example* N.A.A.C.P. v. Button, 371 U.S. 415, 438 (1963).

[26]*See* CSC v. National Ass'n. of Letter Carriers, 413 U.S. 548 (1973); Parker v. Levy, 417 U.S. 1974).

sicians who would frequently be free to exercise their best professional judgment only at the risk of criminal penalties. To be valid, a statute should provide more objective standards, giving firmer indications of the limits of protected conduct.

4. Subsidization of Abortions

Before enacting the Pennsylvania Abortion Control Act, the Pennsylvania Welfare Department promulgated a regulation to the effect that only medically indicated abortions were eligible for state reimbursement under the Medical Assistance Program. A suit challenging the constitutionality of the regulation was just recently decided by the Third Circuit, in banc.[27] To the extent that the issues are identical,[28] I consider myself bound here by the law of this Circuit. My own views, which differ from those of the majority, are noted separately in Doe v. Beale, and it would serve no additional purpose to elaborate them here.

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[27]Doe v. Beale, C.A. Nos. 74-1726, 74-1727, decided July 21, 1975.

[28]As to the section of the Act dealing with financing of abortions for medically indigent women by local communities, there is no mention of such possibility in the record here, and I am aware of no such action or contemplated action—at least in Pennsylvania. Accordingly, I do not consider this issue a justiciable one in the setting of this case, and certainly it is not one that is ripe for constitutional adjudication. *See,* for example, Justice Rutledge's statement in Rescue Army v. Municipal Court, 331 U.S. 549 (1947), and Justice Frankfurter's concurring opinion in Joint Anti-Fascist Refugee Comm. v. McGrath, 341 U.S. 123, 156 (1951).

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 74-2440

Planned Parenthood Association of Southeastern Pennsylvania, Inc., et al

v.

F. Emmett Fitzpatrick, Jr., District Attorney of Philadelphia County, et al

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NEWCOMER, J., Concurring

While the majority opinion expresses my views on most of the issues involved in this case, I feel compelled to set forth separately my views on the issues of parental and spousal consent.

The opinion of the majority, without affirming or denying the existence of any parental rights in the supervision and guidance of unemancipated minor children, finds that the act's parental consent provisions are not narrowly enough drawn to withstand constitutional challenge. While I agree with this conclusion, I am of the view that parents indeed have such rights and that the state may, within certain limitations, legislate to protect these rights. The Supreme Court has not precluded the states from legislating for that purpose and it is generally

recognized that the state may abridge the constitutional rights of minors in situations where it may not abridge those of adults. See, e.g., *Ginsburg v. New York,* 390 U.S. 629 (1968). The Supreme Court has recognized the fundamental right of the parents to choose their children's school, *Pierce v. Society of Sisters,* 268 U.S. 510 (1925), to choose what their children will learn, *Meyer v. Nebraska,* 262 U.S. 390 (1923), and even to decide whether their children will attend school, *Yoder v. Wisconsin,* 406 U.S. 205 (1972). While I am not aware of any case involving a collision between the minor's rights and the parent's right to supervise the minor's upbringing, I believe that the two lines of cases discussed above permit the state to intervene to enforce parental rights.

The state's authority to preserve the right of parents to supervise their children's upbringing rests upon a larger concern: the preservation of the family as the basic unit of our society. This larger interest has been held by the Supreme Court to justify legislation which gives zoning preference to families over non-kinship groups. *Village of Belle Terre v. Boraas,* 416, U.S. 1 (1974). This broader concern includes the relationship between spouses as well as the relationship between parents and children. The participation of one spouse in the important decisions of the other is equally as important to the health of the family as is the participation of the parents in the important decisions of their children.

I believe that the state may take steps to insure such participation as part of its legitimate concern with protecting and preserving the family. Such a concern was undoubtedly in the minds of the Pennsylvania legislators when they enacted the parental and spousal consent pro-

visions of the Abortion Control Act. However, the means which they chose to insure parental and spousal participation—an unqualified veto, without the right of appeal—infringes the constitutional rights of privacy possessed by the family's individual members and is therefore unconstitutional.

That we are today invalidating the means chosen by the legislature should not be interpreted as a refutation of the legitimacy of its goals. I believe that the state could reasonably and constitutionally require a doctor who plans to perform an abortion on a married woman, or an unmarried minor, to notify and inform the husband, or at least one parent, of his plans. In this way the affected family member would be given the opportunity to fulfill his or her role as a source of guidance for, or as the partner of, the pregnant woman. But a statute which gives a parent or a husband an unappealable veto over this one medical decision far exceeds what is necessary to achieve the state's or the other family members' interest, and transgresses upon that private area secured to the woman, whether married or unmarried, adult or minor, by *Roe v. Wade*, 410 U.S. 113 (1973) and *Doe v. Bolton*, 410 U.S. 179 (1973).

Moreover, the Act's parental consent provision suffers from an additional constitutional defect. We note that another Pennsylvania statute, enacted prior to the Abortion Control Act, grants to pregnant minors the right to consent to medical, dental, and health services, and establishes that such consent is effective without the consent of anyone else. 45 Purdon's Statutes §10101. (February 13, 1970). While this law was repealed insofar as it relates to abortion procedures by the Abortion Control Act, this signaling out of abortion appears inconsistent with the Supreme Court's opinions in *Roe* and *Doe*, cited supra. If the Pennsylvania legislature had not granted this general unqualified right to consent to pregnant minors, or if it repealed it *entoto*, the abortion decision would merely be one, rather than the only one, of many health areas in which the parents would have the right to supervise their children.

While I share the philosophy and rationale reflected by most of the views expressed in the separate concurring and dissenting opinion of my respected colleague Judge Adams, I am unable to agree that the parental consent provision can be saved by interpreting the provision's "in loco parentis" language to embrace any "responsible and caring adult who has a close relationship with the young pregnant woman." (Adams, C.J. dissent, at p. 10). While this interpretation is reasonable in the case of orphans or those minors whose parents are mentally incompetent, unknown, or unavailable, it would not appear to be faithful to the spirit of this Act to allow a third-party to consent where the parents are able but unwilling to do so. The Courts, which under the existing provision are not permitted to adjudicate a conflict between parents and minors over the abortion decision, would have to adjudicate conflicts arising from contradictory claims by the natural parents and the person acting "in loco parentis." Moreover, this adjudication would take place not prior to the abortion, but in a criminal proceeding against the physician following the abortion. This procedure would inevitably result in restricting the consent provision to the natural parents, even if this was not the legislature's intent.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 74-2440

Planned Parenthood Association, et al.
Plaintiffs

Obstetrical Society of Philadelphia
Intervenor Plaintiff

vs.

F. Emmett Fitzpatrick, Jr., and Frank S. Beal
Defendants

and

Robert P. Kane and The Commonwealth of Pennsylvania
Intervenor Defendants

ORDER

AND NOW, this 4th day of September, 1975, for the reasons set forth in the Opinion accompanying this Order, IT IS ORDERED that:

(1) State defendants' motions to dismiss Planned Parenthood Association of Southeastern Pennsylvania, Concern for Health Options: Information, Care and Education, Inc., and Clergy Consultation Service of Northeastern Pennsylvania are GRANTED for the reasons set forth in this Court's Opinion.

State defendants' motion to dismiss the Obstetrical Society of Philadelphia is DENIED;

(2) The sections of the Abortion Control Act are declared to be severable and plaintiffs' request to enjoin the Act in its entirety is DENIED;

(3) Section 2's definition of "informed consent", Section 3(a), Section 5(c), Section 6(a), Section 6(c), and Section 8 of the Abortion Control Act are constitutional;

(4) Section 6(d) of the Act is constitutional to the extent that it requires information concerning: "the name, address and age of the woman upon whom the abortion was performed; the date on which the abortion was performed; the date upon which the determination of pregnancy as required by this section was made; . . . ; the approximate age, in months, of the fetus; . . . Affixed to such statement shall be a copy of each of the documents showing consent to abortion as required by section 3 of this act. All information and documents required by this subsection shall be treated with confidentiality customarily accorded to medical records.";

(5) Section 6(d) of the Act is unconstitutional to the extent that it requires information concerning; "the name and address, if known, of the spouse of the woman; the name and address, if known, of the parent or person in loco parentis if the woman is under eighteen years of age and unmarried; . . . ; a full statement of those facts upon which the person performing the abortion relied as establishing that the abortion was necessary to preserve the life or health of the mother.";

(6) Section 2's definition of "viable", Section 3 (b) (i), Section 3 (b) (ii), Section 5 (a), Section 6 (b), Section 6 (f) are unconstitutional; and Section 7 of the Abortion Control Act is inconsistent with Title XIX of the Social Security Act and is unconstitutional; and,

(7) The defendants, their agents, their employees, successors in interest, and all others acting in concert with them, are enjoined from the enforcement of the sections of the Act that have been held by this Court to be unconstitutional.

BY THE COURT:
Arlin M. Adams
Circuit Judge
Clarence C. Newcomer
District Judge
Clifford Scott Green
District Judge

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MEMORANDUM

Before ADAMS, *Circuit Judge* and NEWCOMER and GREEN, *District Judges.*

(Filed September 16, 1977)

GREEN, *District Judge.*

On September 4, 1975, we filed opinions and an order adjudicating constitutional challenges to specific sections of the Pennsylvania Abortion Control Act (Act)[1];

[1]Act No. 209 of 1974, 35 P.S. §7701, *et seq.*

the parties appealed. The Supreme Court of the United States affirmed the judgment of this Court in regard to plaintiffs' appeal; however, on consideration of defendants' appeal the Supreme Court vacated the judgment entered and remanded to this Court "for further consideration in light of *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. —— (1976); *Singleton v. Wulff*, 428 U.S. —— (1976) and *Virginia Citizens Consumer Council*, 425 U.S. —— (1976)."

We have reconsidered the challenged sections in light of the aforesaid decisions of the Supreme Court and enter an order in compliance therewith. Also, the order entered conforms with the stipulation of the parties, except as it relates to section 5(a) of the Act[2]. Since the parties are unable to agree to the proper resolution of the challenge to section 5(a), they have submitted the issue to the Court, on briefs, for decision.

After reconsideration of section 5(a) in light of the most recent Supreme Court decisions, we adhere to our

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[2]Section 5(a) provides:

(a) Every person who performs or induces an abortion shall prior thereto have made a determination based on his experience, judgment or professional competence that the fetus is not viable, and if the determination is that the fetus is viable or if there is sufficient reason to believe that the fetus may be viable, shall exercise that degree of professional skill, care and diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted and the abortion technique employed shall be that which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother.

original view and decision that section 5(a) is unconstitutional[3].

Counsel for the parties have not stipulated as to section 7 of the "Act"[4], electing to have the Court decide the issue after consideration of the decisions of the U.S. Supreme Court in *Beal v. Doe*, —— U.S. ——, 97 S.Ct. 2366, —— L.Ed. 2d —— (1977) and *Maher v. Roe*, —— U.S. ——, 97 S.Ct. 2376, —— L.Ed. 2d —— (1977). We declare section 7 does not violate Title XIX of the Social Security Act, *Beal v. Doe, supra;* nor does section 7 violate the Equal Protection Clause of the Fourteenth Amendment, *Maher v. Roe, supra.*

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[3]Planned Parenthood Association v. Fitzpatrick, 401 F. Supp. 554 (1975).

[4]Section 7 provides:

Since it is the public policy of the Commonwealth not to use public funds to pay for unneeded and unnecessary abortions, no abortion shall be subsidized by any State or local governmental agency in the absence of a certificate of a physician, filed with such body, stating that such abortion is necessary in order to preserve the life or health of the mother.

Nothing contained in this section shall be interpreted to restrict or limit in any way, appropriations, made by the Commonwealth or a local governmental agency to hospitals for their maintenance and operation, or, for reimbursement to hospitals for services performed. 1974, Sept. 10, P.L. 639, No. 209, §7, effective in 30 days.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

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and

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vs.

F. Emmett Fitzpatrick, Jr. and Frank S. Beal,
Defendants,

and

Robert P. Kane and The Commonwealth of Pennsylvania,
Intervenor Defendants.

ORDER

AND NOW, to wit this 16th day of September, 1977, upon consideration of the pleadings, evidence, memoranda filed and in consideration of the stipulation and proposed order counsel filed in this action it is hereby ordered, adjudged and decreed:

I. The following sections of the Pennsylvania Abortion Control Act, Act No. 209 of 1974, 35 P.S. §6601,

et seq. are constitutional and enforceable as set forth below:

Section 2, definition of Viable.

Section 5 (d) insofar as it relates to Section 5 (b)

Section 6 (b)

Section 6 (d) insofar as it relates to the following information: the name, address, and age of a woman upon whom the abortion was performed, the date on which the abortion was performed, the date upon which determination of pregnancy was made; the approximate age of the fetus and, if applicable, a full statement of the facts upon which the person performing the abortion relied on establishing that the abortion was necessary for the life and health of the mother and insofar as it requires patients consent to be affixed to the facility statement.

Section 7. Also, we declare that Section 7 does not violate Title XIX of the Social Security Act.

II. The following sections of the Pennsylvania Abortion Control Act are unconstitutional and therefore enjoined:

Section 3 (b) (i).

Section 3 (b) (ii).

The first sentence of section 3 (e) as it relates to section 3 (b).

Section 5 (a).

Section 5 (d) insofar as it relates to Section 5 (a).

Order Dated Sept. 16, 1977

Section 6(d) insofar as it requires records regarding information related to the spouse or parent of the woman upon whom the abortion was performed, and insofar as it requires the spousal and parental consents to be affixed to the facility statement.

Section 6(f) except insofar as it prohibits physicians from advertising and the plaintiffs' action on this aspect of Section 6(f) is dismissed without prejudice to the members of the class as certified by the District Court. Plaintiffs withdraw any challenge to the prohibition of physicians advertising.

BY THE COURT:

Arlin M. Adams
Circuit Judge

Clarence C. Newcomer
District Judge

Clifford Scott Green
District Judge